Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Kentucky** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of § 1915(c) of the Social Security Act.

B. Program Title:
Supports for Community Living waiver

C. Waiver Number: KY.0314
Original Base Waiver Number: KY.0314.

D. Amendment Number: KY.0314.R03.01

E. Proposed Effective Date: *(mm/dd/yy)*

08/01/11

Approved Effective Date: 08/01/11
Approved Effective Date of Waiver being Amended: 09/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment: The purpose of this amendment is multi-faceted. The changes broaden the array of community based options available for provision of true person-centered, individualized supports based on assessed needs indicated by results of Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST). The broader array of services allows more options for residential supports and greater flexibility for participant directed supports. Greater emphasis is placed on supported employment and community integration. New services have been developed that will provide more person centered supports while creating a career path for direct support professionals who are interested in pursuing career opportunities by participating in training that is offered at no cost to them or the provider. It includes provision of conflict-free case management and steps to ensure choice for individuals and their families. This submission outlines a more effective and comprehensive Continuous Quality Improvement (CQI) plan stressing the cycle of information sharing, action steps and remediation. Included in the quality plan is a more comprehensive, consistent medication administration curriculum developed in collaboration with the Kentucky Board of Nursing and the Department of Public Health to improve the quality of the training, staff competency and reduce medication errors. As this curriculum does require a registered nurse to train staff administering medications, the residential rate paid to providers is increased to offset some of this cost.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver
✓ **Waiver Application**
✓ **Appendix A – Waiver Administration and Operation**
✓ **Appendix B – Participant Access and Eligibility**
✓ **Appendix C – Participant Services**
✓ **Appendix D – Participant Centered Service Planning and Delivery**
✓ **Appendix E – Participant Direction of Services**
✓ **Appendix F – Participant Rights**
✓ **Appendix G – Participant Safeguards**
✓ **Appendix H-Quality Improvement Strategy**
✓ **Appendix I – Financial Accountability**
✓ **Appendix J – Cost-Neutrality Demonstration**

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Kentucky** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of § 1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder):*

Supports for Community Living waiver

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.* **5 years**

Original Base Waiver Number: KY.0314 Waiver Number: KY.0314.R03.01

D. **Type of Waiver** *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/10 Approved
Effective Date of Waiver being Amended: 09/01/10

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Not applicable

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

✓ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less,* briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Kentucky Supports for Community Living (SCL) Medicaid Waiver program offers individualized community based service to divert individuals who have intellectual disabilities and otherwise need institutional services from an ICF/MR and to support individuals who transition from ICF/MR institutional services to the community. Services are delivered with respect, and are designed to ensure individuals are safe in the community and are afforded choices. These services and supports will create a positive culture that promotes person centered thinking through communication, respect, and choice.

GOALS
The SCL Program goals: 1) People receiving waiver services are safe, healthy, and respected in their community; 2) People receiving waiver services live in the community with effective, individualized assistance; and 3) People receiving waiver services enjoy living and working in their community.

OBJECTIVES
The SCL Program objectives are to: 1) to identify individual needs by implementing a comprehensive evaluation utilizing the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST) in order to assist in the person centered planning process leading to development of the plan of care. 2) Ensure home and community based services are comprehensive alternatives to institutional services by providing positive assistive supports as needed to identify and eliminate barriers that create crisis situations. 3) Improve information, access and utilization of employment related supports for participants. 4) Enhance provider competency and continuity of care by offering training and continuing education through the College of Direct Support and through increased collaboration with schools, colleges, and public health entities, seeking human service internship experiences, through the SCL program.

ORGANIZATIONAL STRUCTURE
The Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) serves as the operating agency of the waiver through a contract with the Department for Medicaid Services (DMS). DMS exercises administrative discretion in the operation of the waiver and issues policies, rules and regulations related to the waiver.

SERVICE DELIVERY METHODS
The SCL waiver offers statewide availability of traditional services. Participants can choose to self direct non-medical services also on a statewide basis. They can also choose either all traditional, all self-directed, or a combination (blend) of traditional and self-directed services. If a participant chooses to self direct any services, they are informed of the Community Guide service.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services **Yes. This waiver provides participant direction opportunities.** *Appendix E is required*
F. Participant Rigts. Appendix F specifies how the Stat informs participants of their Medicaid Fair Hearing rights and other procedures ot address participant grievances and complaints.
G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.
I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in § 1 902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1 .F and (b) meet the target group criteria specified in **Appendix B.**

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of § 1 902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy.

Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in § 1902(a)(1) of the Act

No

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C,** adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to § 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C.**

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I.**

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B.**

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B,** the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J.**

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301 (b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D.** All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the

development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301 (b)(1) (ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.31 0(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I.**

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C.**

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of § 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

G. Public Input. Describe how the State secures public input into the development of the waiver:

Early in the development of the waiver, the Commission on Services and Supports for Persons with Intellectual and Developmental Disabilities was informed of the process. This commission is made up of self-advocates, families/guardians, advocates, providers, and state agencies. During their full Commission meetings and subcommittee meetings, the delivery of services and supports was frequently discussed and this information was considered in the writing of the waiver.

In addition, DDID staff has regular involvement with family members and advocacy groups, such as the Arc of Kentucky and the Kentucky Self-Advocates for Freedom. During events such as trainings and conferences, we receive input from these groups regarding their service and support needs and their preferences for directing their services. This information has been useful in the development process.

Four stakeholder forums were conducted to solicit input from Medicaid members, families, advocates and other stakeholders to solicit suggestions and input on what is and isn't working in the current waiver. The input received from stakeholders was considered in drafting the waiver renewal and changes that were cost neutral, efficient and effective were made such as revision of supported employment services and day services to allow more community integration, addition of transportation and nursing support within residential services, and revision of behavior supports to allow for clinical consultative response and training. Additional input was received from various provider and advocacy groups as the waiver was being drafted.

Prior to submission of this waiver to CMS, the waiver was shared with HB 144 commission and subcommittee members for review and comment. Some changes were made based on the feedback received. Commission members expressed concern that there be an exception process when transitioning from the current system to conflict free case management and that exception process in included in this waiver submission.

H. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

I. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Karen Martin

Director of the Division for Community Alternatives

The Department for Medicaid Services

275 East Main Street Mail Stop 6W-B Frankfort, KY 40621

Phone: (502) 564-7540 **Fax:** (502) 564-0249

E-mail: Karen.Martin@ky. Gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is: **Last**

Name: Johnson

First Name: Claudia

Title: Assistant Director

Agency: Department for Behavioral Health, Developmental and Intellectual Disabilities

Address: 100 Fair Oaks Lane

Address 2: Mail Stop 4W-C

City: Frankfort

State: **Kentucky**

Zip: 40621

Phone: (502) 564-7702

Fax: (502) 564-0438

E-mail: Claudia.Johnson@ky.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under § 1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification

requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Karen Martin

State Medicaid Director or Designee

Submission Date: Jun 30, 2011

Last Name: Wise **First Name:** Neville

Title: Acting Commissioner

Agency: Department for Medicaid Services

Address: 275 E Main St, 6W-A **City:** Frankfort **State**: Kentucky **Zip**: 40621

Phone: (502) 564-4321 Fax: (502) 564-0509 Email: neville.wise@ky.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Availability of Current Waiver Services
All services provided under the current Supports for Community Living Home and Community Based Services Waiver will be available in some form in the amended waiver with the exception of fiscal management which will be an administrative function. Several of the current services are deleted and renamed which is detailed below. Current waiver participants will transition from current services to new or revised services during their annual person centered planning meeting in the month of their birthday. No waiver participant will lose services due to this transition.

The current approved waiver offers three similar services called Adult Day Training on site, Adult Day Training off site, and Children's Day Habilitation. These services will be deleted and replaced with Day Training which encompasses all three previous services with one rate.

The current approved waiver offers a service called Community Living Supports which includes training or assistance to an individual who does not receive residential supports and can include a variety of activities designed to increase independence both in the home and in the community. This service will be deleted and replaced with two services, Personal Assistance and Community Access.

Personal Assistance is designed to enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments, and accompanying the waiver participant during medical appointments.

Community Access is designed to support the SCL individual to participate in meaningful routines, events, and organizations in the community. The service stresses training that assists the person in acquiring, retaining, or improving skills related to independent functioning, self advocacy, socialization, community participation, personal and financial responsibility, and other skills related to optimal well-being as defined in the Person Centered Plan of Care (POC). Community Access services are designed to result in increased ability to access community resources by natural or unpaid supports.

The current approved waiver includes residential supports which take place in four settings, staffed residence, group home, family home provider, and adult foster care. This service will be replaced with two residential supports-level I and II each with two levels of supervision. Level I residential will be in a provider owned residence and Level II will be in a non-provider owned residence. Level II will also give the option of residential supports in the recipient's own home. A third residential support, Technology Assisted Residential will also be offered to anyone currently in a staffed residence as a less restrictive alternative. A new service for recipients in their own home called Shared Living, will also be offered as another option to increase independence and choice.

The Support Broker service in the current approved waiver will be replaced with a Community Guide service which will be optional for anyone choosing to self direct any or all of their services. Fiscal management will no longer be a service, it will be bid out to a single entity to provide for all waiver participants who choose to direct any of their services.

The current waiver includes Behavior Supports which is being replaced with three distinct services, 1)Positive Behavior Supports, 2) Consultative Clinical and Therapeutic Services, and 3) Person Centered Coach.

Positive Behavior Supports is designed to assist the individual with significant, intensive challenges that interfere with activities of daily living, social interaction, work or volunteer situations. These services provide for the analysis of data collected during the functional assessment of behavior which is the basis for development of a positive behavior support plan for the acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors.

Consultative Clinical and Therapeutic Service provides expertise, training and technical assistance to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Through this service, a professional may complete an assessment of the individual, the environment and the system of supports, provide recommendations and participate in development/revision of components of a participant's person-centered plan. Individuals may need this service to coordinate program wide support addressing assessed needs, conditions or symptoms affecting their ability to fully participate in their community.

Person Centered Coaching is an individualized service of monitoring, training, and assessing effectiveness of person centered planning. These services provide for modeling, monitoring, assessing and implementing the person centered plan. The Person Centered Coach is responsible for training the individual, family, guardian, natural and paid supports as well as other team members who are recognized as an integral part of person centered planning when barriers challenge the success of the individual in achieving their goals.

The remaining services, Respite, Supported Employment, Occupational Therapy, Speech Therapy, Physical Therapy, Specialized Medical Equipment, Goods & Services remain in the amended waiver with some revision. These revisions will not result in loss of services for any recipient.

New services added to the waiver include:
– Community Transition
– Transportation
– Environmental Accessibility
– Vehicle Adaptation
– Natural Support Training

The term "consumer direction" is being replaced with "participant direction" with no change in function.

Transition Process

As indicated in the section above, "Availability of Current Waiver Services," all participants currently receiving a service under the current approved waiver will not lose services due to the amended waiver. Currently, DDID staff are being trained as SIS interviewers and trainers. Beginning in Waiver Year Two, waiver participants will be assessed according to their birth month. Re-authorization for services and the Person Centered Plan of Care will shift to the participants' birth month at this time. As participants' Plans of Care are developed according to this schedule, participants' continuing need for the services they have been receiving as well as their need for new services will be evaluated and addressed through their respective POC process. All participants will have access to the services in the new waiver and these will be considered based on each participant's needs.

Through the first year transition process, all participants will have access to services in the current approved waiver. As they reach their birth month, services from the new waiver will be phased-in. The process of phase-in of delivery of new services with the participant's birth date and development of his or her POC described above will enable provider agencies to phase-in the delivery of new services for multiple participants overtime, allowing providers to assure service quality in the early implementation period. Case Managers and other POC development stakeholders will have time to consider each participant's needs in the context of new service options. Case Managers will inform waiver participants of their rights to a Fair Hearing, as specified in Appendix F-1. DDID will monitor the implementation of the phase-in plan for new-service delivery through monthly review of POC development. DMS will review DDID's operation of this phase-in plan in its regularly scheduled meetings with DMS. The transition to conflict free case management will be phased in along the same timeline with an exception process in place to ensure participants are allowed to make informed decisions without undue influence.

Self-Directed Supports
In Waiver Year two, as participants switch LOC and Plan renewal dates to birth month, Participants will switch from a Support Broker to Case Manager. New SDS budgets will be completed with new services. Participants receiving residential services will be able to self-direct non-residential services. Family member and legally responsible person guidelines will be applied at this time. Participants who have employees who do not meet the above-mentioned guidelines will work with the case manager on a transition plan for services to be provided by other employees. Case Managers will develop a One-Year transition plan for those employees to be implemented in 3 month increments. The Case Managers and Community Guides (if applicable) will work closely with the participants to ensure qualified employees are located

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver.
The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:
The Department for Behavioral Health, Developmental and Intellectual Disabilities

In accordance with 42 CFR §43 1 . 1 0, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b)*

2. Oversight of Performance.

Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of
Medicaid agency assessment of operating agency performance:

DMS has a written contract with DBHDID that is reviewed annually and is updated as needed. DMS has delegated to DBHDID the following functions through a written contract:
1. Utilization management;
2. Maintenance of waiting list and allocations;
3. Prior Authorization, Plan Review and Level of Care
4. Provider development, training, and certification; and 5.

Quality assurance and quality improvement activities.

DMS and DBHDID are jointly responsible for the following functions:
1. Establishment of a statewide rate methodology; and
2. Developing rules, policies, procedures and information development governing the waiver program

DMS uses the following methods to ensure DBHDID performs its assigned waiver operational and administrative functions in accordance with waiver requirements:
- Policy and clarification is reviewed and approved by DMS;
- DBHDID submits correspondence and reports to DMS;
- DMS and DBHDID hold regular quarterly meetings;
- DMS conducts an annual review of the contract to ensure DBHDID meets all requirements.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable)
Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Operating Agency, the Division of Developmental and Intellectual Disabilities (DDID) within the Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), will determine level of care, prior authorize requests for services and approve the Plans of Care. Fiscal agent services are contracted with a non-governmental agency. The fiscal agent provides processing and payment of provider claims. The DDID's responsibilities include providing supports for members choosing to participate in self direction of non-medical waiver services. In addition, DMS contracts with the DDID to certify non-licensed waiver providers and assist with quality assurance with these providers.
DMS contracts with Department for Community Based Services (DCBS) to determine Medicaid eligibility.

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity. **Not applicable**

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Department for Medicaid Services (DMS) is responsible for assessing the performance of the contracted entities providing Quality Improvement Organization functions, the fiscal agent, and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed: DMS assesses the performance of the contracted agencies continually through policy clarification, post payment auditing processes, second line monitoring, monthly, quarterly, and yearly reporting

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies):*

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	✓	✓	✓
Waiver enrollment managed against approved limits	✓	✓	
Waiver expenditures managed against approved levels	✓	✓	
Level of care evaluation	✓	✓	✓
Review of Participant service plans	✓	✓	✓
Prior authorization of waiver services	✓	✓	✓
Utilization management	✓	✓	
Qualified provider enrollment	✓		
Execution of Medicaid provider agreements	✓	✓	
Establishment of a statewide rate methodology	✓	✓	
Rules, policies, procedures and information development governing the waiver program	✓	✓	
Quality assurance and quality improvement activities	✓	✓	✓

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of utilization management reports completed in a timely manner by the fiscal agent.

Data Source (Select one):
Operating agency performance monitoring If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Annually**	**Less than 100% Review**
	Continuously and Ongoing	**Monitoring of contract**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
	Continuously and Ongoing
	Monitoring of Contract

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DMS contracts with the fiscal agent who in turn contracts with the QIO for medical necessity review. Fiscal agent submits utilization management reports to DMS and the operating agency monthly. DMS and the fiscal agent meet on a regular basis to review and identify issues/problems related to the level of care, plan of care and prior authorization of services. Should problems be identified, then a collaborative plan is developed to resolve the issue/problem.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Identified problems are researched and addressed by DMS and the Fiscal Agent through the use of utilization management reports that are generated on a monthly basis. DMS monitors the Fiscal Agent to ensure that contract objectives and goals for LOC are met as appropriate. Should the Fiscal Agent not meet the requirements then a corrective action plan is required and/or a recoupment of fund could occur.

i. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
QIO	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently nonoperational.

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DMS will meet with fiscal agent to develop reports that meet this performance measure by 3-30-12. Responsible parties will be fiscal agent and DMS. Plan to transition medical necessity review, plan of care and prior authorization of services from QIO to state operating agency within the third year of the waiver.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(1 0)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441. 301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	**Included**	**Target SubGroup**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
Mental Retardation or Developmental Disability, or Both					
		Autism			
	✓	**Developmental Disability**	3		✓
	✓	**Mental Retardation**	3		✓

b. Additional Criteria. The State further specifies its target group(s) as follows:

Developmental disability is defined as: a disability that: (a) Is manifested prior to the age of twenty-two (22);(b) Constitutes a substantial disability to the affected individual; and (c) Is attributable to an Intellectual Disability or related condition that: Results in impairment of general intellectual functioning and adaptive behavior similar to that of a person with an intellectual disability; and are a direct result of, or are influenced by, the person's cognitive deficits.

Adaptive behavior means the person has overall adaptive behavior which is significantly limited in three or more skill areas (self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency) as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit*:* **Not applicable. There is no maximum age limit.**

B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3767
Year 2	4055
Year 3	4101
Year 4	4151
Year 5	4201

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way:

The state does not limit the number of participants that it serves at any point in time during a waiver year.

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval.

The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes
Money Follows the Person (MFP)
Emergency Need

Purpose *(provide a title or short description to use for lookup):* Money Follows the Person (MFP)

Purpose *(describe):* To assure the availability of slots for those transitioning from ICF/MR or nursing facility through the Money Follows the Person grant.

Describe how the amount of reserved capacity was determined: Based on trends from the past three fiscal years

The capacity that the State reserves in each waiver year is specified in the following table:

	Capacity Reserved
Year1	66
Year2	88
Year3	46
Year 4 (renewal only)	50
Year 5 (renewal only)	50

Appendix B: Participant Access and Eligibility

Purpose Emergency Need

Purpose *(describe):* To assure the availability of slots for those considered in an emergency need status.

Describe how the amount of reserved capacity was determined:

Determined based on allocations over the past five years

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	229
Year 2	233
Year 3	68
Year 4	68
Year 5	68

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule **The waiver is not subject to a phase-in or a phase-out schedule.**

e. Allocation of Waiver Capacity. Waiver capacity is allocated/managed on a statewide basis.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

As long as capacity exists, eligible applicants will be selected for waiver entrance based on the date of their waiver application. If waiver capacity is not adequate for all eligible applicants, individuals will be selected for waiver entrance based on the date of their waiver application and their category of need, with individuals in crisis meeting criteria for emergency need receiving preference.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a **§1634 State**
2. **Miller Trust State – YES**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ✓ Low income families with children as provided in §1931 of the Act
- ✓ SSI recipients
- ✓ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. All individuals in the special home and community-based waiver group under 42 CFR §435.217

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1 924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousalpost-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.2 17 *(select one):*

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to **Use spousal post-eligibility rules under § 1924 of the Act.** *(Complete Item B-5-b (SSI State) and Item B-5-d)*

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 43 5.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in § 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant

The following formula is used to determine the needs allowance: SSI standard plus SSI general exclusion

ii. Allowance for the spouse only – Not Applicable

iii. Allowance for the family - Medically needy income standard

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

The State does not establish reasonable limits.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of § 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under § 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

The following formula is used to determine the needs allowance:

SSI Standard plus the $20 General Exclusion

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Allowance is the same

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

The State does not establish reasonable limits.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluaions) of the needfor the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is 1.

ii. Frequency of services. The State requires **the provision of waiver services at least monthly.**

iii. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed **by the operating agency specified in Appendix A**

iv. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441 .303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Bachelor's Degree, or higher, in human service field, from an accredited college or university; OR
Bachelor's degree in any other field from an accredited college or university, with at least one(1) year experience in the field of intellectual disability; OR
Registered Nurse currently licensed as defined in KRS 314.011(5), and who has one (1) year or more experience as a professional nurse in the field of intellectual disability; AND
Shall be supervised by a case management supervisor who shall have two (2) years or more experience as a case manager.

v. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Currently, the applicant's Level of Care (LOC) is developed utilizing MAP 351 assessment. Kentucky will begin a phase-in of the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). The SIS includes information about the member's support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. Currently, DDID staff are being trained as SIS interviewers and trainers. Beginning in Waiver Year Two, participants will be assessed according to their birth month. Re-authorization for services and the Person Centered Plan of Care will shift to the participants' birth month at this time. As participants' Plans of Care are developed according to this schedule, participants' continuing need for the services they have been receiving as well as their need for new services will be evaluated and addressed through their respective POC process. All participants will have access to the services in the new waiver and these will be considered based on each participant's needs.

The HRST screens for overall health risk related to disability and aging, and provides the case manager and support team with guidance in determining the person's need for further assessment and evaluation to address identified health risks. The HRST will be conducted by providers statewide on the plan renewal date beginning in Waiver Year Three.

Once fully implemented, LOC will be determined by a Supports Intensity Scale (SIS). This assessment will be submitted along with a psychological evaluation or other documentation to support the ID/DD diagnosis.

Level of care criteria used to evaluate and reevaluate waiver eligibility per 907 KAR 1:022:
An individual shall meet ICF-MR-DD patient status if the individual requires physical or environmental management or rehabilitation for moderate to severe intellectual disability and meets the following criteria:

(a) The individual has significant developmental disabilities or significantly subaverage intellectual functioning and requires a planned program of active treatment to attain or maintain the individual's optimal level of functioning, but does not necessarily require nursing facility or nursing facility with waiver services;

(b) The individual requires a protected environment due to developmental disabilities and sub average intellectual functioning while:

1. Learning fundamental living skills;
2. Learning to live happily and safely within his own limitations;
3. Obtaining educational experiences that will be useful in self-supporting activities; or
4. Increasing his awareness of his environment; or

(c) The individual has a psychiatric primary diagnosis or needs if:

1. The individual also has care needs as shown in paragraph (a) or (b) of this subsection;
2. The psychiatric care needs are adequately met in a supportive environment (i.e., the intermediate care facility for individuals with intellectual disability or a developmental disability); and
3. The individual does not require psychiatric inpatient treatment.

An individual who does not require a planned program of active treatment to attain or maintain the individual's optimal level of functioning shall not meet ICF-MR-DD patient status.

An individual shall not be denied ICF-MR-DD services based solely on advanced age, or length of stay in an institution, or history of previous institutionalization, if the individual qualifies for ICF-MR-DD services on the basis of all other factors.

Excluding an individual with an intellectual disability, for an individual with a developmental disability to qualify for ICF-MR-DD services, the disability shall have manifested itself prior to the individual's 22nd birthday.

State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency, including the instrument/tool utilized.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one):*

The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441 .303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

All applicants must have an order stating that an Intermediate Care Facility for the ID/DD is needed and must be signed by a Physician, Nurse Practitioner, or Physician Assistant. If the assessment meets the LOC guidelines then the assessor is notified. The reevaluation process utilizes the same assessment tool-SIS, but does not require an additional psychological evaluation or other supporting documentation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule **Every twelve months**

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441 .303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(speci5y):*

The state of Kentucky requires that re-evaluations be performed at least every 12 months. The Case Manager or state assessors will complete the Supports Intensity Scale (SIS). Once the SIS results are entered, DDID staff will use this information to evaluate if the person meets the Level of Care (LOC) needed for admittance to an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled. If the person meets the LOC then a waiver segment with a date range of one year is entered into the Medicaid Management Information System (MMIS). If the waiver segment is not updated, then a provider of services will not be paid.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441 .303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written documentation of the evaluations and reevaluations shall be maintained by the Case Manager and agencies providing services to the member. Electronic documentation shall be maintained by the DDID. All records shall be maintained a minimum of six (6) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver applicants who had a level of care indicating the need for institutionalization. N= Total number of applicants who had a level of care evaluation indicating the need for institutionalization D= Total number of waiver applicants

Data Source (Select one):
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	
QIO		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
QIO	

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of waiver participants whose level of care was reevaluated within 12 months of their initial level of care evaluation or of their last annual level of care evaluation. N= Total number of participants who had a level of care redetermination within 12 months D= All waiver participants

Data Source

On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	
Other QIO		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
QIO	

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of level of care eligibility determination packets that were returned. N=Total number of level of care eligibility determination packets returned D=Total number of level of care determinations

Data Source (Select one):
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

Performance Measure:
Percent of waiver participants reviewed by QIO whose initial or subsequent level of care eligibility was appropriately determined as required by the state. N= Number of randomly selected waiver participants whose level of care was done appropriately D= Total number of levels of care reviewed

Data Source (Select one): **Record reviews, on-site**
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Monthly**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
QIO	

vi. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS addresses problems as discovered through the use of utilization management reports which are generated by the fiscal agent and the QIO for evaluation/reevaluation. These reports show number of new participants who received LOC prior to services being provided, shows number of timely reevaluations, and forms/instruments completed as required by the state. DMS will meet with the fiscal agent in order to identify and remediate the problem.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
Other: QIO	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DMS will meet with fiscal agent to develop reports that meet this performance measure by 3-30-12. Responsible parties will be fiscal agent and DMS.

DMS will transition medical necessity review, plan of care and prior authorization of services from QIO to state operating agency during the third year of the waiver. This transition will begin with the completion of the RFP process for utilization management which includes a waiver data system to enable the operating agency to perform and track these functions.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver members are informed of their choice of institutional care or waiver programs and available services, including all available waiver providers by participating Case Management waiver providers. This information is provided at the initial evaluation and at each reevaluation and documented on the MAP-350, “Long Term Care Facilities and Home and Community Based Program Certification Form”. Written copies of this signed form is retained in the persons chart and maintained by the Case Management provider. The freedom of choice form is completed annually or when a participant changes case management providers.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies are maintained by the DDID and Providers.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Kentucky Medicaid providers are required to provide effective language access services to Medicaid members who are limited in their English proficiency (LEP). Specific procedures for assuring LEP access may vary by provider, but are required to address assessment of the language needs of members served by the provider, provision of interpreter services at no cost to the member, and staff training.

As indicated in Appendix A, Waiver Administration and Operation, of this application, the Department for Medicaid Services (DMS) contracts with several state and contracted entities to perform waiver administrative functions, including level of care determination and prior authorization of services, processing and payment of provider claims, and fiscal intermediary services. In addition, the Department for Community Based Services, a governmental unit within the Cabinet for Health and Family Services, determines technical and financial eligibility for Medicaid services.

All of these entities are required, through contract, to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for persons who are limited in their English proficiency. Contractors' language services must be consistent with Federal requirements, include a method of identifying LEP individuals, and provide language assistance measures including interpretation and translation, staff training, providing notice to LEP persons, and monitoring compliance and updating procedures. The Cabinet for Health and Family Services has established a Language Access Section to assist all Cabinet organizational units, including DMS, in effectively communicating with LEP individuals, as well as complying with Federal requirements. The Language Access Section has qualified interpreters on staff, maintains a listing of qualified interpreters for use by CHFS units and contractors throughout the state, contracts with a telephone interpretation service for use by CHFS units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to CHFS, and provides technical assistance to CHFS units as needed. Procedures employed by individual departments and units, including DMS, include posting multi-lingual signs in waiting areas to explain that interpreters will be provided at no cost; using "I Speak" cards or a telephone language identification service to help identify the primary language of LEP individuals at first contact; recording the primary language of each LEP individual served; providing interpretation services at no cost to the individual served; staff training; and monitoring of staff offices and contractors.
Provider procedures for assuring LEP access are ensured through routine interaction and monitoring. When the State learns of an individual needing assistance, staff consult with the individual, ease manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the individual. The Waiver has a mechanism to fund translation services through the Map 95 process.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table.*

Service Type	Service
Statutory Service	**Case Management**
Statutory Service	**Community Access**
Statutory Service	**Day Training**
Statutory Service	**Personal Assistance**
Statutory Service	**Residential Support Level I**
Statutory Service	**Respite**
Statutory Service	**Shared Living**
Statutory Service	**Supported Employment**
Extended State Plan Service	**Occupational Therapy**
Extended State Plan Service	**Physical Therapy**
Extended State Plan Service	**Speech Therapy**
Supports for Participant Direction	**Community Guide**
Supports for Participant Direction	**Goods and Services**
Supports for Participant Direction	**Natural Supports Training**
Supports for Participant Direction	**Transportation**
Other Service	**Assessment/Reassessment**
Other Service	**Community Transition**
Other Service	**Consultative Clinical and Therapeutic Service**
Other Service	**Environmental Accessibility Adaptation Services**
Other Service	**Person Centered Coaching**
Other Service	**Positive Behavior Supports**
Other Service	**Residential Support Level II**
Other Service	**Specialized Medical Equipment and Supplies**
Other Service	**Technology Assisted Level I Residential Support**
Other Service	**Vehicle Adaptation**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Service Definition *(Scope):*

Case management involves working with the individual and others that are identified by the individual such as family member(s) in developing a Person Centered Plan of Care (POC). Case management is responsible for the assessment, reassessment, appropriate evaluations, intake, referral, and eligibility processes. Using person centered planning process, case management assists in identifying and implementing support strategies. These strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal and community supports. Case managers will work closely with the individual to assure his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. Case managers will assure that participants have freedom of choice of providers in a conflict free climate.

Case management involves face-to-face and related contacts to make arrangements for activities which assure the following: The health, safety and welfare of the individual are met, the desires and needs of the individual are determined, the supports and services desired and needed by the individual are identified and implemented; housing and employment issues are addressed, social networks are developed, and appointments and meetings are scheduled. A person-centered approach to planning is provided while utilizing waiver and other community supports. The quality of the supports and services as well as the health and safety of the individuals are monitored. Case manager will assist participant in managing benefits as needed. Activities are documented, and plans for supports and services are reviewed at least annually and more often as needed utilizing person centered planning processes. The CM or designee must be able to respond to a call regarding a crisis event within 15 minutes and be able to respond or send a designee within 45 minutes if necessary.

Case management shall not include direct services. Agencies providing case management services to a person may not also provide other waiver services to that same person. This prohibition applies to subsidiaries, partnerships, not-for-profits or other business entities that are under the control of the same umbrella agency.

Case managers employed by a qualified provider shall have:

Bachelor's Degree- or higher degree- in human service field, from an accredited college or university; OR Bachelor's degree in any other field, from an accredited college or university, with 1 year experience in the field of intellectual disability; OR
Registered Nurse currently licensed as defined in KRS 314.011(5), and who has one (1) year or more experience as a professional nurse in the field of intellectual disability; AND
Shall be supervised by a case management supervisor who shall have 2 years experience as a case manager.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Case Management is billed as one monthly unit.

Service Delivery Method

Provider Managed

Specifications:

Provider Category	Provider Type Title
Agency	Certified SCL waiver providers
Agency	Certified or licensed Medicaid providers

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Name: Case Management

Provider Category:
Agency
Provider Type: Certified SCL waiver providers
Provider Qualifications: Must meet all DDID personnel and training requirements.
Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Statutory Service
Name: Case Management

Provider Category:
Agency
Provider Type: Certified or licensed Medicaid providers
Provider Qualifications Must meet all DDID personnel and training requirements.
Verification of Provider Qualifications
Entity Responsible for Verification: Certified providers-DBHDID
Licensed providers-Office of Inspector General (OIG)
Frequency of Verification: Certified providers-Initially and at least every 2 years thereafter
Licensed providers-annually

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Community Access
Service Definition *(Scope):*
Community Access services are designed to support the SCL individual to participate in meaningful routines, events, and organizations in the community. The service stresses training that assists the person in acquiring, retaining, or improving skills related to independent functioning, self advocacy, socialization, community participation, personal and financial responsibility, and other skills related to optimal well-being as defined in the Person Centered Plan of Care (POC).

Community Access services are designed to result in increased ability to access community resources by natural or unpaid supports. Community Access services shall have an emphasis on the development of personal social networks for the waiver participant. They are provided outside the person's home or family home. These services may occur during the day, in the evenings and on weekends. Community Access services may not duplicate residential or other day habilitation services or authorized therapies. Considering the preferences of the person/family, the planning team recommends the content, location (s), and mode(s) of learning that will best meet the needs of each person.
Community Access Services are provided to a person with a one-to-one staff to participant ratio and shall take place in an integrated community setting. Community Access is an impact service and should decrease in need as the person becomes more independent in accessing and becoming a part of the community.
While the service is typically provided 1:1, planning team may authorize 1 staff for a small group of no more than 2 on case by case basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: A unit of service is 15 minutes. Community Access is limited to 160 units per week.

Any combination of community access, day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day.

Appendix C: Participant Services

C-1/C-3: Service Specification

Service Delivery Method *(check each that applies):*

- ✓ Participant-directed as specified in Appendix E
- ✓ Provider Managed

Specify whether the service may be provided by *(check each that applies):*

- ✓ **Legally Responsible Person**
- ✓ **Relative**
- ✓ **Legal Guardian Provider**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Access Specialist
Agency	SCL Certified agency

Service Type: Statutory Service Service
Name: Community Access

Provider Category:

Individual

Provider Type:
Community Access Specialist

Provider Qualifications:

DDID standards for Community Access staff are:
a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis; AND
c. Meets all applicable DDID personnel and training requirements.
d. Driver must be at least 18 years of age, hold a valid, Class C State of Kentucky driver's license, have no major traffic violations and have current mandatory insurance;

Verification of Provider Qualifications

Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Service Type: Statutory Service Service
Name: Community Access

Provider Category:

Agency

Provider Type: SCL Certified agency
Provider Qualifications: Meets all applicable DDID standards for a waiver provider agency.

Employs staff with the following qualifications:
DDID standards for CA Specialist are:
a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis; AND
c. Meets all applicable DDID personnel and training requirements.
d. Hold a valid class C State of KY driver's license, have no major traffic violations, and has current mandatory insurance.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Training

Service Definition *(Scope):*

Day Training (DT) services are intended to support the participation of people in daily, meaningful, routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment. DT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The training, activities, and routines established shall not be diversional in nature but rather, shall be meaningful to the person, shall provide an appropriate level of variation and interest, and shall assist the person to achieve personally chosen outcomes which are documented in the Person Centered Plan of Care (POC).

DT services can be provided at a fixed location, or in community settings. Services provided in a fixed location are typically provided on a regularly scheduled basis, no more than five days per week. The hours must be spent in training and program activities and must be based on the person's Plan of Care. Support services lead to the acquisition, improvement, and/or retention of skills and abilities to prepare the person for work and/or community access or transition from school to adult responsibilities and community integration. DT may be provided as an adjunct to other services included on a person's support plan. For example: a person may receive supported employment or other services for part of a day or week and DT services at a different time of the day or week. DT services will only be billable for the time that the person actually received the service. DT may also include group approaches to work related training that occur in community settings (mobile work crews, enclaves, entrepreneurial models). Any person receiving DT services that are performing productive work that benefits the organization, or would have to be performed by someone else if not performed by the person, must be paid. People who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

In addition to work-related training, DT may include involvement in community based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population. DT can be used to provide access to community-based activities that cannot be provided by natural or other unpaid supports, and is defined as activities designed to result in increased ability to access community resources without paid supports.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service: 15 minute units. Day Training is limited to 160 units per week alone or in combination with Supported Employment.

Any combination of community access, day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day.

Service Delivery Method

- ✓ Participant-directed as specified in Appendix E
- ✓ Provider Managed

Specify whether the service may be provided by *(check each that applies):*

- ✓ **Legally Responsible Person**
- ✓ **Relative**
- ✓ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified DT Staff
Agency	Certified agency employing qualified DT staff

Service Type: Statutory Service Service Name:
Day Training

Provider Category:

Individual

Provider Type:
Qualified DT Staff
Provider Qualifications
1. Is eighteen (18) years or older; and Has a high school diploma or GED; is or is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Verification of Provider Qualifications

Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Service Type: Statutory Service Service Name:
Day Training

Provider Category:

Agency

Provider Type:
Certified agency employing qualified DT staff **Provider Qualifications**

Meets all applicable DDID standards for a waiver provider agency; employs staff with the following qualifications:
1. Is eighteen (18) years or older; and Has a high school diploma or GED; or is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Assistance

Service Definition *(Scope):*

Personal assistance services enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments, and accompanying the waiver participant during medical appointments.

Transportation to access community services, activities and appointments shall not duplicate State plan transportation services. Personal assistance services take place in the waiver participant's home, and in the community as appropriate to the individual's need.

Personal assistance services are available only to a waiver participant who lives in his /her own residence or in his/her family residence. Personal assistance supports are not available to any waiver participant receiving paid residential supports.

Without these services, the individual is at risk of needing ICF/MR services. Personal assistance services are not available to individuals under the age of21 when medically necessary personal assistance services are covered by EPSDT. Personal assistance services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15 minutes.

Any combination of community access, day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day.

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in**
- ✓ **Appendix E Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ✓ **Legally Responsible Person**
- ✓ **Relative**
- ✓ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	SCL Certified agency
Agency	Home health agency
Individual	Qualified personal assistance staff
Agency	Private Duty Nursing Agencies
Agency	Adult day health care agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name:
Personal Assistance

Provider Category:

Agency

Provider Type:
SCL Certified agency

Provider Qualifications:

Meets all applicable DDID standards for a waiver provider agency;
Employs staff with the following qualifications:
1.Is eighteen (18) years or older; and Has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instruction c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Statutory Service Service Name:
Personal Assistance

Provider Category:

Agency

Provider Type:
Home health agency

Provider Qualifications

License 902 KAR20:066

Other Standard

Meets all applicable standards for a waiver provider agency;
Employs staff with the following qualifications:
1.Is eighteen (18) years or older; and has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2.Meets all applicable DID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the individual/family; b) understand and carry out instructions; c) perform required documentation.

Supervisory staff must also have 2 years experience in supporting individuals with DD and complete a supervisory training curriculum approved by DID.

Verification of Provider Qualifications

Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name:
Personal Assistance

Provider Category:

Individual

Provider Type:
Qualified personal assistance staff

Provider Qualifications

1.Is eighteen (18) years or older; and Has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;
c) perform required documentation; and
5.Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Case Manager
Frequency of Verification:
Prior to service delivery

Service Type: Statutory Service Service Name:
Personal Assistance

Provider Category:

Agency

Provider Type:
Private Duty Nursing Agencies

Provider Qualifications

License 902 KAR20:370
Other Standard
Employs staff with the following qualifications:
1.Is eighteen (18) years o older; and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Verification of Provider Qualifications

Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name:
Personal Assistance

Provider Category:

Agency

Provider Type:
Adult day health care agency

Provider Qualifications

License 902 KAR20:081

Other Standard

Meets all applicable standards for a waiver provider agency;

Employs staff with the following qualifications:

1.Is eighteen (18) years or older; and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and

2.Meets all applicable DDID personnel and training requirements;

3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Supervisory staff must also have 2 years experience in supporting individuals with DD and complete a supervisory training curriculum approved by DID.

Verification of Provider Qualifications

Entity Responsible for Verification: Office of Inspector General

Frequency of Verification: Initially and annually thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):
Residential Support Level I

Service Definition *(Scope):*
Level I Residential Supports are targeted for people who require 24 hour intense level of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of residents.

Residential support may include the provision of up to five (5) unsupervised hours per day per person as identified in the person centered Plan of Care (POC) to promote increased independence which shall be based on the individual needs of a person as determined with the person centered team and reflected in the POC. Unsupervised hours are based upon the Plan of Care developed in the person centered planning process. Those who cannot safely be unsupervised would not be unsupervised. The supports required for each participant will be outlined in their Person Centered Plan which includes a Crisis Prevention Plan.

For each participant approved for any unsupervised time, a safety plan will be created based upon their assessed needs. The Case Manager, as well as other team members, will ensure the participant is able to implement the safety plan. On-going monitoring of the safety plan, procedures or assistive devices required would be conducted by the Case Manager to ensure relevance, ability to implement and functionality of devices if required.

If an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. If changes are anticipated to be chronic (lasting more than 3 months), the residential provider may request reassessment to determine if needs have changed. Any increase in funding based on assessed needs shall be used for provision of additional supports as outlined in a revised POC. The residential provider is responsible for informing DDID once the person has returned to previous status so that Residential Service Level can return to previous status. When Residential services are authorized for an individual, the determination of the level is based on information from the individual's Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and approved POC.
The agency providing residential supports is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J.

Level I Residential supports are furnished in a provider owned residence with variable rates based on three or fewer persons in the residence; vs. four or more persons in the residence. Provider owned or leased residences where residential services are furnished must be compliant with the Americans with Disabilities Act based on the needs of the persons supported.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a separate rate for residential provided to more than 3 persons in one location.

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Specifications:

Provider Category	Provider Type Title
Agency	Certified Group Home Provider
Agency	Certified Staffed Residence

Service Type: Statutory Service
Service Name: Residential Support Level I

Provider Category:
Agency
Provider Type:
Certified Group Home Provider
Provider Qualifications
License 902 KAR20:078
Other Standard
Meets all applicable DDID standards for a waiver provider agency; employs staff with the following qualifications:
1. Is eighteen (18) years or older; and Has a high school diploma or GED;or is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.
Verification of Provider Qualifications
Entity Responsible for Verification: OIG **Frequency of Verification:** Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

Service Type: Statutory Service
Service Name: Residential Support Level I

Provider Category:

Agency

Provider Type:
Certified Staffed Residence

Provider Qualifications:

Meets all applicable DDID standards for a waiver provider agency; employs staff with the following qualifications:
1.Is eighteen (18) years or older; and Has a high school diploma or GED; or is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Service Definition *(Scope):*
Respite Services are provided to individuals living in their own or family's home who are unable to independently care for themselves. Respite services are provided on a short term basis due to the absence of or need for relief of the primary caregiver.

Respite may be provided in a variety of settings including the individual's own home, a private residence or other SCL certified residential setting. Receipt of respite care does not preclude an individual from receiving other services on the same day. For example, a participant may receive day services (such as supported employment, day training, personal assistance, community access, etc.) on the same day as he/she receives respite care as long as the services are not provided at the same time.

A provider may not use another person's bedroom or another person's belongings in order to provide respite for a different person. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.). **Specify applicable (if any) limits on the amount, frequency, or duration of this service:** Unit of service: 15 minutes
Limited to 830 hours per year.

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in**
- ✓ **Appendix E Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ✓ **Relative**
- ✓ **Legal Guardian**

Specifications:

Provider Category	Provider Type Title
Individual	Qualified respite staff
Agency	Certified agency that employs qualified Respite staff

Service Type: Statutory Service Service
Name: Respite

Provider Category:

Individual

Provider Type:
Qualified respite staff

Provider Qualifications

1.Is eighteen (18) years or older; and Has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;c) perform required documentation.

Verification of Provider Qualifications

Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Service Type: Statutory Service Service
Name: Respite

Provider Category:

Agency

Provider Type:
Certified agency that employs qualified Respite staff

Provider Qualifications

Meets all applicable DDID standards for a waiver provider agency;
Employs staff with the following qualifications:
1.Is eighteen (18) years or older; and
Has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

Shared Living

Service Definition *(Scope):*

This service is designed as an alternative to residential services and allows a person to live in their own home with a roommate/live-in caregiver to provide some of their supports. The caregiver may provide overnight supervision and necessary personal assistance, or may provide assistance during waking hours depending on the need of the person. Persons receiving shared living service may also receive other approved waiver services.

Caregiver living expenses are the portion of the room and board that may be reasonably attributed to a live-in caregiver who also provides unpaid assistance with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, supervision required for safety and the social and adaptive skills necessary to enable the participant to reside safely and comfortably in his or her own home. The service must be provided to an enrollee, living in his or her own home and the live-in caregiver must reside in the same home. For purposes of this service, "food" includes three meals a day. If two waiver recipients choose to live together in a home, they may share a live in caregiver.

Allowable Activities:

- Under Medicaid and § 1634 and SSI criteria rules, in order for the payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be routed through the provider specifically for the reimbursement of the waiver participant
- Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service)
- Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services
- Board: three meals a day or other full nutritional regimen
- Unrelated: unrelated by blood or marriage to any degree including a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild.
- Caregiver: An individual providing service determined by a person centered process and documented in the Plan of Care to meet the physical, social or emotional needs of the participant receiving services.
- Service Standards:
- Room and board for an Unrelated Live-in Caregiver should be reflected in the prior approved Plan of Care for the individual, or in the case of a live in caregiver providing support to two individuals, the plan of care for each will be taken into consideration in determining the total amount of room and board.
- Services must address needs identified in the person centered planning process and be outlined in the Plan of Care and specified in contractual agreement between the waiver recipient(s) and the live in caregiver.
- Services must complement other services the participant receives and enhance increasing independence for the participant
- The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the participant and the type of support needed

Documentation Standards:

Room and board documentation for the Unrelated Live-in Caregiver must:

- Be identified in the Plan of Care and specified in contractual agreement between the waiver recipient and live in caregiver.
- Include documentation of how amount of Room and board expenditure was determined
- Show receipt that funds were paid to the live-in caregiver
- Include a monthly summary note that indicates services were provided according to the Plan of Care.

Payment will not be made when the SCL individual lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in**
- ✓ **Appendix E Provider managed**

Legal Guardian Provider Specifications:

Provider Category	Provider Type Title
Agency	SCL Waiver approved case Management Agency
Individual	Individuals hired by Participants who Self Direct

Service Type: Statutory Service Service Name:

Shared Living

Provider Category:

Agency

Provider Type:

SCL Waiver approved case Management Agency

Provider Qualifications

The agency ensures that the caregiver meets the following qualifications:
1.Is eighteen (18) years or older; and Has a high school diploma or GED; or
Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

The agency ensures that the caregiver meets the following qualifications prior to being alone with the Individual:
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- ability to participate as a member of the team if requested by the individual

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Statutory Service Service Name:
Shared Living

Provider Category:

Individual

Provider Type:

Individuals hired by Participants who Self Direct

Provider Qualifications

The case manager ensures that the live-in caregiver meets the following qualifications prior to employment:
1.Is eighteen (18) years or older; and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

The case manager ensures that the live-in caregiver meets the following qualifications prior to being alone with the Individual:
•demonstrate competence/knowledge in topics required safely support the individual as described in the Individual Plan
-ability to participate as a member of the team if requested by the individual

Verification of Provider Qualifications

Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to Service Delivery

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Service Definition *(Scope):*

Supported employment is paid, competitive employment at or above minimum wage for an SCL recipient who has demonstrated an inability to gain and maintain traditional employment. Supported Employment occurs in a variety of integrated business environments. Phases of Supported Employment include: Job Development, Job Acquisition, Successful Placement and Long Term Follow up. Supported employment is a one to one service that shall be person specific.
Job Development must begin with Discovery (Person-Centered Job Selection), where job goal/features of desired employment are selected based on spending time with the person in non-standardized non-standardized/nontesting situations to learn his gifts, talents and support needs.
Person Centered Job Selection is achieved by completing a "Person Centered Employment Plan" (PCEP), and includes job planning meetings and job analysis. The job planning meetings involve convening and networking with trusted people; matching job characteristics with job tasks and then with types of employers and finally with specific employers - mapping a way for effective job development. Job analysis is conducted to determine the culture of the business, possibilities for customized employment, how people typically learn their jobs, who teaches them and how long training typically takes. Job development may also focus on interviewing skills/interview support, resume development and assistance with filling out applications. Customized employment is essential to individualize the employment relationship between the employer and the supported employee in ways that meet the needs for both.

Acquisition is the actual acceptance of a position by the individual. During this phase, the individual will receive training on how to perform the job tasks. Natural Supports available in the workplace should be developed and utilized from the beginning. Other training could include, but is not limited to the following: social interaction, medication scheduling, chain of command, documentation of time (timesheets, clocks) hygiene issues, mobility, conflict resolution, when and from whom it is appropriate to seek assistance, and personnel policies. Additional training in exploring transportation options, utilization and schedule may also be needed. These trainings can occur both on and off the job site. The expectation is for systemic fading of the Employment Specialist to begin as soon as possible without jeopardizing job placement. Successful placement shall be when natural supports are relied on more fully and fading of the employment specialist from the worksite begins.

Additionally, before a successful placement can be determined there must be confirmation that the employee is functioning well at the job. Consideration should include not only the person's general satisfaction, but also the number of hours worked, performance of job duties and other basics, his/her comfort level on the job, and interaction with coworkers and supervisors.

Other less visual, but essential aspects of the job, which if unattended, could jeopardize the employee's future must also be considered. The development of natural supports in the work environment is a critical role of the Employment Specialist during this phase and it may be necessary to write Impairment Related Work Expense (IRWE) plans or Plans for Achieving Self Support (PASS) for the employee or access other waiver services to address individualized needs. The expectation is for systemic fading of the Employment Specialist to begin as soon as possible without jeopardizing job placement.

Long Term Follow-up is support provided to maintain the job placement and the continued success after the individual is fully integrated into the workplace and the Employment Specialist is no longer needed at the job site on a regular basis. The Employment Specialist must continue to be available, if and when needed for support or assistance with job changes/job advancements. Activities could include, but are not limited to the following: problem-solving, retraining, regular contact with employer, employee, family, co-workers, other SCL staff and reassessment of an employee with regard to career changes or position upgrades. During this phase the Employment Specialist is required to make at least two contacts per month, one of which should be at the worksite.

Services do not include services that are available under Section 110 of the Rehabilitation Act of 1973 (or, in the case of youth, under the provisions of IDEA, (20 U.S.C. 1401 et seq.). The state will determine that such services are not available to the participant before authorizing their provision as a waiver service. Documentation that services are not otherwise available is maintained in the file of each participant receiving this service. Waiver funding is not available for the provision of Supported Employment services (e.g., sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties.

Transportation provided through Supported Employment service is included in the cost of doing business and incorporated in the administrative overhead cost.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service: Unit of service: 15 minutes

Job Development is limited to 50 hours or 200 units per job for a maximum of three episodes per year.

Any combination of community access, adult day training, supported employment and personal assistance service, plus hours the person spends performing paid employment may not exceed 64 units (16 hours) per day. Supported employment plus day training may not exceed 160 units per week.

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in**
- ✓ **Appendix E Provider managed**

Provider Category	Provider Type Title
Individual	**Supported Employment Specialist**
Agency	**SCL certified agency employing supported employment specialists**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name:
Supported Employment

Provider Category:

Individual

Provider Type:
Supported Employment Specialist

Provider Qualifications

Certificate
Completion of the UK HDI KY Supported Employment Training Project or comparable training approved by DDID, within 6 months of the date the specialist begins providing SCL SE services.

Other Standard
DDID standards for SE Specialist are:

a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis; AND
c. Meets all applicable DDID personnel and training requirements.

Verification of Provider Qualifications
Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Service Type: Statutory Service Service Name:
Supported Employment

Provider Category:

Agency

Provider Type:
SCL certified agency employing supported employment specialists

Provider Qualifications

Completion of the UK HDI KY Supported Employment Training Project or comparable training approved by DDID, within 6 months of the date the specialist begins providing SCL SE services.
Meets all applicable DDID standards for a waiver provider agency.
Employs staff with the following qualifications:
DDID standards for SE Specialist are:

a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis; AND
c. Meets all applicable DDID personnel and training requirements.

Verification of Provider Qualifications Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

Service Definition *(Scope):*

Occupational Therapy Services are provided by a licensed occupational therapist or certified occupational therapist assistant, and by order of a physician. Occupational Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the participant that result from his or her developmental disability as well as development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Occupational therapy facilitates maximum independence by establishing life skills with an emphasis on safety and environmental adaption to improve quality of life and increase meaning and purpose in daily living and community integration. Occupational Therapy promotes fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services include occupational therapy evaluation of the individual and/or environment, therapeutic activities to improve functional performance, sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, and participant/family education. Services may be delivered in the individual's home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.

Occupational Therapy services must be prior authorized. Occupational Therapy Services through the waiver are not available to waiver participants under the age of21 since the services are covered under the State Plan EPSDT benefit for this age group. Services provided by an occupational therapy assistant must be supervised by a licensed occupational therapist.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 52 fifteen minute units per month.

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Legal Guardian Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved SCL Waiver provider employing qualified professional
Agency	Medicaid enrolled Adult Day Health Care Agency
Agency	Medicaid enrolled Home Health agencies

Service Type: Extended State Plan Service Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Approved SCL Waiver provider employing qualified professional

Provider Qualifications

License KRS 319A.010

Other Standard

All standards identified in program regulations and services manual AND employ professionals qualified to provide service or certified occupational therapy assistants supervised by a licensed occupational therapist.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID

Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service Service Name:
Occupational Therapy

Provider Category:

Agency

Provider Type:
Medicaid enrolled Adult Day Health Care Agency **Provider Qualifications**

License 902 KAR 20:081

Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service or certified occupational therapy assistants supervised by a licensed occupational therapist.

Verification of Provider Qualifications

Entity Responsible for Verification: Office of the Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Extended State Plan Service Service Name:
Occupational Therapy

Provider Category:

Agency

Provider Type:
Medicaid enrolled Home Health agencies
Provider Qualifications

License 902 KAR20:066

Other Standard
All standards identified in program regulations and services manual AND employs professional qualified to provide service or certified occupational therapy assistants supervised by a licensed occupational therapist.

Verification of Provider Qualifications

Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

Service Definition *(Scope):*
Physical Therapy services are provided by a licensed physical therapist or certified physical therapy assistant, and by order of a physician. Physical Therapy Services cover evaluation and therapeutic services that are not otherwise covered under Medicaid State Plan services.

These services address physical therapy needs that result from a participant's developmental disability. Physical Therapy Services facilitate independent functioning and/or prevent progressive disabilities. Covered services include: physical therapy evaluation, therapeutic procedures, therapeutic exercises to increase range of motion and flexibility, participant/family education and assessment of an individual's environment. Services also include development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Services may be delivered in the individual's home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.

Appendix C: Participant Services

C-1/C-3: Service Specification

Physical Therapy Services must be prior authorized. Physical Therapy Services through the waiver are not available to waiver participants under the age of21 since the services are covered under the State Plan EPSDT benefit for this age group. Services provided by a physical therapist assistant must be supervised by a licensed physical therapist.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 52 fifteen minute units per month.

Service Delivery Method

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved SCL Waiver providers employing qualified professionals
Agency	Medicaid enrolled adult day health care agency
Agency	Medicaid enrolled home health agency

Service Type: Extended State Plan Service Service Name:
Physical Therapy

Provider Category:
Agency

Provider Type:
Approved SCL Waiver providers employing qualified professionals **Provider Qualifications**

License KRS 27.010

Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service, or
Certified physical therapy assistants who are supervised by a licensed physical therapist. **Verification of Provider Qualifications**

Entity Responsible for Verification: DBHDID

Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Extended State Plan Service Service Name:
Physical Therapy

Provider Category:
Agency

Provider Type:
Medicaid enrolled adult day health care agency
Provider Qualifications

License 902 KAR 20:081

Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service, or Certified physical therapy assistants who are supervised by a licensed physical therapist.

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Department for Medicaid Services
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Extended State Plan Service Service Name:
Physical Therapy

Provider Category:

Agency

Provider Type:
Medicaid enrolled home health agency
Provider Qualifications
License *(speci5y):* 902 KAR20:066
Other Standard *(speci5y):*
All standards identified in program regulations and services manual AND employs professional qualified to provide service, or
Certified physical therapy assistants who are supervised by a licensed physical therapist **Verification of Provider Qualifications**
Entity Responsible for Verification: Office of the Inspector General
Department for Medicaid Services
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

Service Definition *(Scope):*
Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. Evaluation of the individual and their living and working environments may be conducted.

These services address the speech and language needs of the participant that result from his or her developmental disability. Speech and Language Therapy Services preserve abilities for independent function in communication, motor and swallowing functions, facilitate use of assistive technology, and/or prevent regression. Specific services include speech and language therapy evaluation, individual treatment of voice, communication, and/or auditory processing, therapeutic services for the use of speech-device, including programming and modification, and participant/family education. Services also include development of a home treatment/support plan with training and technical assistance provided on-site to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions.

Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. Services may be delivered in the individual's home and in the community as described in the service plan. Attendance is expected at Person Centered Planning meeting which is not a separate billable service.
Speech and Language Therapy Services must be prior authorized. Speech and Language Therapy Services through the waiver are not available to waiver participants under the age of21 since the services are covered under the State Plan EPSDT benefit for this age group.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to 52 fifteen minute units per month.

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved SCL Waiver provider
Agency	Medicaid enrolled Adult day health care agency
Agency	Medicaid enrolled Home health agency

Service Type: Extended State Plan Service Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:
Approved SCL Waiver provider
Provider Qualifications
License KRS 334A.020
Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service
Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Extended State Plan Service Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:
Medicaid enrolled Adult day health care agency **Provider Qualifications**
License*:* 902 KAR 20:081
Other Standard
All standards identified in program regulations and services manual AND employ professionals qualified to provide service.
Verification of Provider Qualifications
Entity Responsible for Verification:
Office of Inspector General **Frequency of Verification:** Initially and annually thereafter

Service Type: Extended State Plan Service Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:
Medicaid enrolled Home health agency
Provider Qualifications
License 902 KAR20:066
Other Standard
All standards identified in program regulations and services manual AND employ professionals qualified to provide service.
Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter by OIG

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Community Guide

Service Definition *(Scope):*

Community Guide services are designed to empower individuals to define and direct their own services and supports. These services are only for persons who opt for self directed supports for either some or all of their support services. The person determines the amount of Community Guide services, if any, and the specific services that the Community Guide will provide. Community Guide Services include direct assistance to persons in brokering community resources and in meeting their consumer directed responsibilities. Community Guides provide information and assistance that help the person in problem solving and decision making and in developing supportive community relationships and other resources that promote implementation of the Plan of Care. The Community Guide service includes providing information to ensure the person understands the responsibilities involved with directing his or her services. The exact direct assistance provided by the Community Guide to assist the person in meeting consumer directed responsibilities depends on the needs of the person and includes assistance, if needed with recruiting, hiring, training, managing, evaluating, and changing employees, scheduling and outlining the duties of employees, developing and managing the individual budget, understanding provider qualifications, record keeping, and other requirements.

Community Guide services do not duplicate Case Management services. Case managers facilitate the team in development of the Person Centered Plan of Care (POC), link the person to medical and waiver services including community guide services, ensure services in the plan are properly implemented, and monitor the delivery of services including Community Guide services. The specific Community Guide services to be received by a person are specified in the POC. Community Guide services must be authorized prior to service delivery at least annually in conjunction with the POC and with any POC revisions.

Limitations:

- Community Guides may not provide other direct waiver services, including Case Management, to any waiver participant.
- Community Guides may not be employed by an agency that provides other direct waiver services, including Case Management.
- Community Guide agencies cannot provide Case Management services.
- A person serving as a representative for a waiver participant receiving participant directed services is not eligible to be a Community Guide for that person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit of service: 15 minutes Limit: 576 units per year

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**
- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Community Guide
Agency	Certified SCL Provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction Service
Name: Community Guide

Provider Category:

Individual

Provider Type:
Qualified Community Guide
Provider Qualifications
Other Standard
DBHDID standards for Community Guides are:
a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis;
c. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
d. Meets all applicable DDID personnel and training requirements.

Verification of Provider Qualifications
Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to Service Delivery

Service Type: Supports for Participant Direction Service
Name: Community Guide

Provider Category:

Agency

Provider Type:
Certified SCL provider agency
Provider Qualifications
Other Standard
Meets all applicable DDID standards for a waiver provider agency.
Employs staff with the following qualifications:
a. Minimum of bachelor's degree and one year of experience in the field of developmental disabilities.
b. Relevant experience and/or credentialing will substitute for education on a year for year basis; c.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and d.Meets all applicable DDID personnel and training requirements.
Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Goods and Services

Service Definition *(Scope):*

Goods and Services are services, equipment or supplies that are individualized to the person or their representative who chooses to Self Direct their services. Goods and services may be utilized to reduce the need for personal care or to enhance independence within the home or community of the person. These services are not otherwise provided through the Medicaid State Plan but address an identified need in the Person Centered Plan of Care/Support Spending Plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Individual Directed Goods and Services are purchased from the participant-directed budget, must be prior authorized. Experimental or prohibited treatments are excluded.

The specific goods and services provided under Goods and Services must be clearly linked to a participant need that has been identified through a specialized assessment, established in the Support Spending Plan and documented in the participant's POC. Goods and services purchased under this coverage may not circumvent other restrictions on waiver services, including the prohibition against claiming for the costs of room and board.

The person/representative must submit a request to the Case Manager for the goods or service to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipts that provide clear evidence of the purchase must be on file in the participant's records to support all goods and services purchased. Authorization for these services requires Case Manager documentation that specifies how the Goods and Services meet the above-specified criteria for these services.

An individual serving as the representative of a waiver participant for whom the goods and service are being purchased is not eligible to be a provider of Individual Directed Goods and Services. The Financial Manager, a Medicaid enrolled provider, makes direct payments to the specified vendor.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**

Provider Specifications:

Provider Category	Provider Type Title
Individual	**Individual Vendor**
Agency	**Agency Vendor**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction Service
Name: Goods and Services

Provider Category:

Individual

Provider Type:
Individual Vendor
Provider Qualifications
Other Standard
Have an applicable business license for goods or services provided
Understands and agrees to comply with the self-directed services and goods delivery requirements **Verification of Provider Qualifications**
Entity Responsible for Verification:
Case Manager
Frequency of Verification:
Prior to service delivery

Service Type: Supports for Participant Direction Service
Name: Goods and Services

Provider Category:

Agency

Provider Type: Agency
Vendor **Provider Qualifications**
License Applicable business license as required by the local, city, or county government in which the service is provided.
Other Standard
Must have employees providing services that:
Have an applicable business license for goods or services provided
Understands and agrees to comply with the participant directed services and goods delivery requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Case Manager
Frequency of Verification:
Prior to service delivery

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):
Natural Supports Training

Appendix C: Participant Services

C-1/C-3: Service Specification

Service Definition *(Scope):*
Natural Supports Training Services (NST) provides training and education to individuals who provide unpaid support, training, companionship or supervision to participants for the purpose of accomplishing or improving provision of supports. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services specified in the person centered Plan of Care (POC), and includes updates as necessary to safely maintain the participant at home. NST Services include the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the POC. Natural Supports Training Services do not include the costs of travel, meals and overnight lodging to attend a training event or conference. All training for individuals who provide unpaid support to the participant must be included in the participant's POC.
Natural Supports Training Services do not include services reimbursable by any other source. NST Services must not be duplicative of any education or training provided through Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. Natural Supports Training Services may not occur simultaneously with Adult Physical Therapy Services, Adult Occupational Therapy Services, Adult Speech and Language Therapy Services, or Behavioral Supports Consultation Services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Natural Supports Training Services. Training and consultation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the plan of care development and with any POC revisions. **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor

Service Type: Supports for Participant Direction Service
Name: Natural Supports Training

Provider Category:
Individual
Provider Type:
Independent Contractor **Provider Qualifications**
Other Standard
Registered and in good standing with Kentucky Secretary of State **Verification of Provider Qualifications**
Entity Responsible for Verification:
Case Manager
Frequency of Verification:
Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Transportation

Service Definition *(Scope):*

Transportation Services enable waiver participants who choose to self direct their services to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Transportation services and the unavailability of other resources for transportation must be documented in the Person Centered Plan of Care (POC).

Transportation Services exclude transportation to and from Community Access Services that entail activities and settings primarily utilized by people with disabilities. Persons receiving Residential Services are not eligible to receive participant directed Transportation Services. Transportation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Plan of Care development and with any POC revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**

Specify whether the service may be provided by *(check each that applies):*

- ✓ **Legally Responsible Person**
- ✓ **Relative**
- ✓ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Driver
Agency	Licensed Drivers
Agency	Certified Waiver providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction Service Name: Transportation

Provider Category:

Individual

Provider Type: Licensed Driver

Provider Qualifications

Other Standard

Driver must be at least 18 years of age, hold a valid, Class C State of Kentucky driver's license, and have no major traffic violations;

Has current mandatory insurance;

Agrees to or provides required documentation of criminal background check.

Has the training or skills necessary to meet the participant's needs as demonstrated by documented prior experience or training on providing services to individuals with I/DD and in addressing any disability-specific needs of the participant;

Meets all applicable BHDID Standards

Verification of Provider Qualifications

Entity Responsible for Verification: Case Manager

Frequency of Verification: Prior to service delivery

Service Type: Supports for Participant Direction Service Name: Transportation

Provider Category:

Agency

Provider Type:

Licensed Drivers

Provider Qualifications

Other Standard

Applicable state/local business license and applicable vehicle liability insurance; employee shall have background checks and a valid, applicable driver's license.

Must provide commercial carrier services to the community at large

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDID

Frequency of Verification:

Initially and as needed thereafter

Service Type: Supports for Participant Direction Service Name: Transportation

Provider Category:

Agency

Provider Type:

Certified Waiver providers

Provider Qualifications

Certificate Certified, at least annually, by the department or its designee

Other Standard *(specify):* All standards identified in program regulations and services manual.

Applicable state/local business license and applicable vehicle liability insurance;

Must ensure that any driver is at least 18 years of age, holds a valid, Class C State of Kentucky driver's license, have no major traffic violations, has current mandatory insurance, has a criminal background check, and has required training or prior experience.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID

Frequency of Verification: Initially and as needed thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assessment/Reassessment

Service Definition *(Scope):*

All individuals will be assessed at entry into the waiver and reassessed at least every twelve (12) months or more often if their needs change. The assessment/reassessment will be utilized to make a level of care determination.

At the time of the level of care assessment waiver participants and/or their guardians/representatives will be provided information to make an informed choice as to the options available to them, how services will be accessed and all providers available for the provision of waiver services.

The agency representative conducting the assessment must observe the individual in the individual's home.

The assessment information, will be provided to DBHDID for review and level of care determination for all waiver participants. State Medicaid staff retains final decision authority for the level of care determination. Individuals denied level of care are notified and allowed the right to exercise their appeal rights under the state fair hearing rights.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to one unit per member, per year, or as their needs change.

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Center
Agency	Home Health Agency
Agency	Other approved waiver providers

Service Type: Other Service
Service Name: Assessment/Reassessment

Provider Category:

Agency

Provider Type:

Adult Day Health Care Center **Provider Qualifications**

Licens*e:* 902 KAR20:066

Verification of Provider Qualifications

Entity Responsible for Verification: Office of Inspector General

Frequency of Verification: Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assessment/Reassessment

Provider Category:

Agency

Provider Type:
Home Health Agency **Provider Qualifications**

License 902 KAR 20:081
Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Other Service
Service Name: Assessment/Reassessment

Provider Category:

Agency

Provider Type:
Other approved waiver providers
Provider Qualifications 907 KAR 1:145

Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every two years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

Service Definition *(Scope):*
Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; (g) activities to assess need, arrange for and procure needed resources; and (h) caregiver training. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person centered plan of care development process, clearly identified in the person centered plan of care and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services are limited to one time set-up expenses

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Guide-Agency
Agency	SCL Waiver Residential Provider
Agency	SCL Case Management Provider

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
Community Guide-Agency
Provider Qualifications
SCL waiver provider certified to provide community guide services
Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
SCL Waiver Residential Provider
Provider Qualifications
SCL waiver provider certified to provide residential services **Verification of Provider Qualifications**
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:
SCL Case Management Provider
Provider Qualifications
SCL waiver provider certified to provide case management services **Verification of Provider Qualifications**
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultative Clinical & Therapeutic Service

Service Definition *(Scope):*

Service provides expertise, training and technical assistance to improve the ability of paid and unpaid caregivers to carry out therapeutic interventions. Through this service, a professional may complete an assessment of the individual, the environment and the system of supports, develop a home treatment plan to facilitate improvement, maintain skills or to prevent decline, provide recommendations and participate in development/revision of components of a participant's person-centered plan. Individuals may need this service to coordinate program wide support addressing assessed needs, conditions or symptoms affecting their ability to fully participate in their community.

This service is provided by licensed or certified professionals in psychology, nutrition or counseling; OR a positive behavior specialist. These service providers must also have at least two years of direct service experience with individuals with intellectual or developmental disabilities.

The service may include consultation, assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home and in the community as described in the service plan. This service also encompasses psychological treatment as indicated by the condition of the individual. Participation is expected at Plan of Care meeting which is not a separate billable service.

This service may also include direct monitoring of implementation of the home treatment/support plan and/or the person-centered plan as well as direct supervision of the Person Centered Coach by the supervising Positive Behavior Specialist.

The plan of care shall specify the scope of consultative clinical and therapeutic services that are needed and shall identify the type of professional(s) required.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service: 120 units/year

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home health agency
Agency	Approved waiver providers
Agency	Adult day health care agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Service

Provider Category:

Agency

Provider Type:
Home health agency
Provider Qualifications
License*:* 902 KAR20:066
Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service WHO,
Has two (2) years of direct service experience with individuals with intellectual or developmental disabilities
Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Service

Provider Category:

Agency

Provider Type:
Approved waiver providers
Provider Qualifications
All standards identified in program regulations and services manual AND employs professionals qualified to provide service WHO,
Has two (2) years of direct service experience with individuals with intellectual or developmental **Verification of Provider Qualifications**
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Service

Provider Category:

Agency

Provider Type:
Adult day health care agency **Provider Qualifications License** 902 KAR 20:081
Other Standard
All standards identified in program regulations and services manual AND employs professionals qualified to provide service WHO,
Has two (2) years of direct service experience with individuals with intellectual or developmental disabilities,
Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptation Services

Service Definition *(Scope):*

Environmental Accessibility Adaptation services consist of adaptations which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Environmental Accessibility Adaptation Services consist of physical adaptations to the waiver participant's or family's home which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services shall be provided in accordance with applicable state and local building codes.

Environmental Accessibility Adaptation services will not be approved for homes that are provider owned. Environmental Accessibility Adaptation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Plan of care development and with any revisions. **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor
Agency	Certified or licensed waiver CM providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation Services

Provider Category:

Individual

Provider Type:
Independent Contractor

Provider Qualifications

Registered and in good standing with Kentucky Secretary of State **Verification of Provider Qualifications**

Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation Services

Provider Category:

Agency

Provider Type:
Certified or licensed waiver CM providers

Provider Qualifications

License OIG licensed CM provider 902 KAR20:066
DBHDID certified CM provider **Other Verification of Provider Qualifications**

Entity Responsible for Verification: Certified providers-DBHDID Licensed providers-Office of Inspector General (OIG)
Frequency of Verification: Certified providers-Initially and at least every 2 years thereafter Licensed providers-annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Person Centered Coaching

Service Definition *(Scope):*

Person Centered Coaching is an individualized service of monitoring, training, and assessing effectiveness of person centered planning. These services provide for modeling, monitoring, assessing and implementing the person centered plan. The service is delivered by a Person Centered Coach who assists the person and the team in implementing and assessing effectiveness of the Plan of Care (POC). The coach models person centered thinking. The Person Centered Coach is responsible for training the individual, family, guardian, natural and paid supports as well as other team members who are recognized as an integral part of person centered planning when barriers challenge the success of the individual in achieving their goals.

Staff training developed by the Person Centered Coach shall be developed in conjunction with appropriately qualified personnel. For example, if challenge or barrier is related to sensory integration issue then the OT who evaluates or treats the participant should participate at least in development of the training. If the participant's targeted behavior is related to a mental illness, such as depression, then a mental health professional who is knowledgeable of the participant's manifestation of the mental illness, should participate in at least the development of the training.

The Person Centered Coach operates independently of a residential or Day Training provider and must be under the supervision of a Positive Behavior Specialist. This service may include development of a structured coping plan, wellness plan or recovery plan. Dependent on the assessed needs of the individual, the Person Centered Coach may complete assigned duties related to completion of a functional assessment of behavior which would be utilized to make modifications to the environment, person centered plan, coping plan, and/or crisis prevention plan. A Person Centered Coach is not to be considered as part of staffing ratio, plan or pattern since the coaching duties are separate from those of a Direct Support Professional.

The service is not intended to be an indefinite part of an individual's support system but may come in and out of their circle of supports as needed, i.e. utilized when there is a significant change in status or the person centered plan. The service shall be outcome based and documented.. When developing outcomes, a plan for the gradual withdrawal of the services shall be established. This service shall not duplicate case management or any other service. These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.). **Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Unit of Service is 15 minutes. Annual limitation on units is 1320

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved SCL Waiver providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Person Centered Coaching

Provider Category:

Agency

Provider Type:
Approved SCL Waiver providers

Provider Qualifications

Meets all applicable DDID standards for a waiver provider agency;
Employs qualified staff who shall have:
1)A high school diploma or GED, 2 years of experience in the field of I/DD plus completion of specialty training; OR
2)Completed 12 hours of college coursework in applicable course of study plus completion of specialty training;
3)Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and 4)Meets all applicable DDID personnel and training requirements; and
5)Performs required documentation

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Positive Behavior Supports

Service Definition *(Scope):*
Positive Behavior Supports is a service to assist the individual with significant, intensive challenges that interfere with activities of daily living, social interaction, work or volunteer situations. These services provide for the utilization of data collected during the functional assessment of behavior: this is the basis for development of a positive behavior support plan for the acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors. The plan is intended to be implemented across service settings and by individuals assisting the person in meeting their dreams and goals. Intervention modalities described in plans must relate to the identified behavioral needs of the individual, and specific criteria for remediation of the behavior must be established and specified in the plan. The need for the plan shall be evaluated and revisions made as needed and at least annually. It is expected that need for this service will be reduced over time as an individual's skills develop.

Prior authorization is required prior to the commencement of services. Revisions to the positive behavior support plan may be covered through the service consultative clinical and therapeutic services when recommended by the planning team and approved by the prior authorization authority.

These services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming in addition to two (2) years of direct experience with individuals with intellectual or developmental disabilities. Completion of state approved trainings is also mandatory.

These services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.). **Specify applicable (if any) limits on the amount, frequency, or duration of this service:** A unit of service is 1 item (functional assessment and plan) reimbursed at a standard fixed fee.

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid enrolled adult day health care agency
Agency	Medicaid enrolled home health agency
Agency	Approved SCL Waiver providers

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:
Agency
Provider Type:
Medicaid enrolled adult day health care agency
Provider Qualifications
License 902 KAR 20:081
Other Standard
All standards identified in program regulations and services manual.
Services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming; AND
Two (2) years of direct service experience with individuals with intellectual or developmental disabilities, AND
Complete state approved training annually.

Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:
Agency
Provider Type:
Medicaid enrolled home health agency
Provider Qualifications
License 902 KAR20:066
Other Standard
All standards identified in program regulations and services manual.
Services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming; AND
Two (2) years of direct service experience with individuals with intellectual or developmental disabilities, AND
Complete state approved training annually.
Verification of Provider Qualifications
Entity Responsible for Verification: Office of Inspector General
Frequency of Verification: Initially and annually thereafter

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Behavior Supports

Provider Category:

Agency

Provider Type:

Approved SCL Waiver providers

Provider Qualifications

All standards identified in program regulations and services manual.
Services are provided by professionals with at least a Master's Degree in behavioral science and one (1) year of experience in behavioral programming; AND
Two (2) years of direct service experience with individuals with intellectual or developmental disabilities, AND
Complete state approved training annually.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Residential Support Level II

Service Definition *(Scope):*
Level II Residential Supports are targeted for people who require up to 24 hour levels of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the person to reside in the most integrated setting appropriate to his/her needs. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of the recipients.

Residential support Level II may include the provision of on-call support with a minimum of one face-to-face contact per day in the residence to promote increased independence as identified in the Plan of Care (POC) developed with the person centered team.

Residential Level II provides support up to 24 hours a day service; therefore, if an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. If changes are anticipated to be chronic (lasting more than 3 months), the residential provider may request reassessment to determine if needs have changed as reflected in a revised POC. Any increase in funding based on assessed needs shall be used for provision of additional supports. The residential provider is responsible for informing DDID once the person has returned to pervious status so that Residential Level can return to previous status. When Residential services are authorized for an individual, the determination of the level is based on information from the individual's Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and approved Individual Plan of Care (POC).

The agency providing residential supports is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations.
Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J.

Level II Residential supports are furnished in a non-provider owned residence with variable rates based on required hours of support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Adult Foster Care Provider
Agency	Certified Family Home Provider
Agency	Certified Provider

Service Type: Other Service
Service Name: Residential Support Level II

Provider Category:

Agency

Provider Type:
Certified Adult Foster Care Provider
Qualifications
Meets all applicable DDID standards for a waiver provider agency;
Employs staff with the following qualifications:
1. Is eighteen (18) years or older and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Other Service
Service Name: Residential Support Level II

Provider Category:

Agency

Provider Type:
Certified Family Home Provider
Provider Qualifications

License 902 KAR20:078
Other Standard
Meets all applicable DDID standards for a waiver provider agency;
Employs staff with the following qualifications:
1.Is eighteen (18) years or older; and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2.Meets all applicable DDID personnel and training requirements;
3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

Service Type: Other Service
Service Name: Residential Support Level II

Provider Category:
Agency

Provider Type:
Certified Provider

Provider Qualifications

Meets all applicable DDID standards for a waiver provider agency; Employs staff with the following qualifications:
Meets all applicable DDID standards for a waiver provider agency;
Employs staff with the following qualifications:
1. Is eighteen (18) years or older and has a high school diploma or GED; or Is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
4. Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.
5. Hold a valid class C State of KY driver's license, and have no major traffic violations, and has current mandatory insurance.

Supervisory staff must also have 2 years experience in supporting persons with DD and complete a supervisory training curriculum approved by DDDID.

Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Medical Equipment & Supplies

Service Definition *(Scope):*
Specialized Medical Equipment and Supplies consists of devices, controls or appliances specified in the Plan of Care, which are necessary to ensure the health, welfare and safety of the individual or which enable the person to function with greater independence in the home, and without which, the member would require institutionalization. Services may also consist of assessment or training needed to assist waiver participants with mobility, seating, bathing, transferring, security or other skills such as operating a wheelchair, locks, doors openers or side lyres. Equipment consists of computers necessary for operating communication devices, scanning communicators, speech amplifiers, control switches, electronic control units, wheelchairs, locks, door openers, or side lyres. These services also consist of customizing a device to meet a waiver participant's needs.

Supplies consist of food supplements, special clothing, adult protective briefs, bed wetting protective chucks, and other authorized supplies that are specified in the Individual Service Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service.

When equipment and supply needs are covered under State Plan services such as but not limited to Durable Medical Equipment (DME), EPSDT, Orthotics and Prosthetics and Hearing Services programs, the equipment and supplies must be accessed through these programs to the extent the need can be met. All items covered through these programs must be requested through the respective programs.

The need for specialized medical equipment and supplies must be identified in the Plan of Care and must be recommended by a qualified rehabilitation technician or engineer, occupational therapist, physical therapist, augmented communication therapist or other qualified therapist whose signature also verifies the type of specialized equipment or supply that is necessary to meet the individual's need.. Specialized Medical Equipment and Supplies must be authorized prior to service delivery by the operating agency in conjunction with the annual Plan of Care or an amended Plan of Care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service: no limit

Based on submission of 3 price estimates

Service Delivery Method *(check each that applies):*

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care agencies
Agency	Home Health Agencies
Agency	Certified waiver providers

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Adult Day Health Care agencies
Provider Qualifications
License 902 KAR20:066
Other Standard
All standards identified in program regulations and services manual.
Verification of Provider Qualifications
Entity Responsible for Verification: Office of the Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Home Health Agencies **Provider Qualifications**
License *(*902 KAR 20:081
Other Standard
All standards identified in program regulations and services manual.
Verification of Provider Qualifications
Entity Responsible for Verification: Office of the Inspector General
Frequency of Verification: Initially and annually thereafter

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:
Certified waiver providers
Provider Qualifications
All standards identified in program regulations and services manual.
Verification of Provider Qualifications
Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Technology Assisted Level I Residential Support

Service Definition *(Scope):*
Technology assisted Level I Residential Supports are targeted for people who require up to 24 hour support but are able to increase their independence with reduced need for onsite staff. The use of technology is to assist the participant to reside in the most integrated setting appropriate to his/her needs as determined with the team in the Person Centered Plan of Care (POC). TA Residential support must also include, to the extent required, protective oversight and supervision, transportation, personal assistance and the provision for or arrangement for necessary medical and health care services that are integral to meeting the daily needs of recipient. The intent of this service is to increase independence without undue risk to a person's health and safety. Careful consideration must be given regarding a person's medical, behavioral and psychiatric condition(s) when considering this service.

Use of available technology to reduce the need for residential staff support in the home may be utilized if there is an individualized plan developed to promote increased independence based on the individual needs as determined by the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and the individual's circle of supports. Technology assisted residential supports is a real time monitoring system with a two-way communication linking the waiver recipients home to a centralized monitoring station. This may include the use of electronic sensors, speakers and microphones, video cameras (not in bedrooms or bathrooms), smoke detectors, temperature detectors, and personal emergency response systems. These devices link each individual's home to remote staff that provides electronic support. The residential provider must have a plan in place to ensure staff are available twenty four hours a day seven days a week and demonstrate the ability to respond timely to emergencies, and to assess the situation, on-site if needed, and ensure health, safety and welfare.

Technology assisted Residential support is a 24 hour a day service; therefore, if an individual experiences a change in support needs or status, the provider shall immediately adjust supervision (up to and including going on-site to the residence) to meet acute needs and shall reassess the appropriateness of these supports and adjustments shall be made to meet chronic support needs.

The agency providing residential supports is responsible to arrange for or provide transportation between the participant's place of residence and other service sites and community locations.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix J.

Technology assisted Level I Residential supports are furnished in a provider owned residence to persons who previously resided in the residence with 24 hour staff support; with no more than three persons receiving these supports in a residence. Provider owned or leased residences where residential services are furnished must be compliant with the Americans with Disabilities Act based on the needs of the person supported.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method

- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified SCL Level I Residential Provider

Service Type: Other Service
Service Name: Technology Assisted Level I Residential Support

Provider Category:

Agency

Provider Type:

Certified SCL Level I Residential Provider

Provider Qualifications

Meets all applicable DDID standards for a waiver provider agency;
Employs on-site staff with the following qualifications:
1. Is eighteen (18) years or older with a high school diploma or GED; or is at least twenty-one (21) years old; and
2. Meets all applicable DDID personnel and training requirements;
3. Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
4. Has the ability to: a) communicate effectively with the individual/family; b) understand and carry out instructions; c) perform required documentation
5 .Drivers must be at least 18 years of age, hold a valid, Class C State of Kentucky driver's license, and have no major traffic violations; and have proof of current mandatory insurance;"

Supervisory staff must also have 2 years experience in supporting individuals with DD and complete a supervisory training curriculum approved by DDID.

Verification of Provider Qualifications

Entity Responsible for Verification: DBHDID
Frequency of Verification: Initially and at least every 2 years thereafter

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Other Service

As provided in 42 CFR §440.1 80(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Adaptation

Service Definition *(Scope):*

Vehicle Adaptation services enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These adaptations are limited to a waiver participant's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving.

SCL is the payer of last resort for vehicle adaptations. The need for Vehicle Adaptation must be documented in the plan of care. Repair or replacement costs for vehicle adaptations of provider owned vehicles are not allowed. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the DMS. Vehicle Adaptation must be authorized prior to service delivery by the operating agency in conjunction with the plan of care and with any POC revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Delivery Method *(check each that applies):*

- ✓ **Participant-directed as specified in Appendix E**
- ✓ **Provider managed**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified or Licensed Case Management provider
Individual	Independent Contractor

Service Type: Other Service Service Name:
Vehicle Adaptation

Provider Category:

Agency

Provider Type:
Certified or Licensed Case Management provider
Provider Qualifications
License OIG licensed CM provider 902 KAR20:066
Certificate DBHDID certified CM provider
Verification of Provider Qualifications
Entity Responsible for Verification: Certified providers-DBHDID Licensed providers-Office of Inspector General (OIG)
Frequency of Verification: Certified providers-Initially and at least every 2 years thereafter Licensed providers-annually

Service Type: Other Service
Service Name: Vehicle Adaptation

Provider Category:

Individual

Provider Type:
Independent Contractor
Provider Qualifications License
Registered and in good standing with Kentucky Secretary of State
Verification of Provider Qualifications
Entity Responsible for Verification: Case Manager
Frequency of Verification: Prior to service delivery

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

c.Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants.
Case management is furnished as a distinct activity to waiver participants as a waiver service defined in Appendix C-3.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All employees of enrolled waiver providers and employees of members participating in participant direction are required to submit to a state criminal background check. DMS or DBHDID conduct initial certification and at least every two years thereafter of all waiver providers. During the provider certification, employee records are reviewed to verify compliance with the criminal history check requirement. Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of the waiver providers and employees of participants directing non-medical waiver services are required to submit to screening through state registries which are the Child Abuse and Neglect (CAN) registry maintained by the Department for Community Based Services (DCBS), and the Nurse Aide Registry maintained by the Kentucky Board of Nursing (KBN). DMS or DBHDID conduct initial and recertifications of all waiver providers. During the recertification, employee records are reviewed to ensure that mandatory registry screenings have been completed. Licensed providers are inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to § 1616(e) of the Act:

Facility Type
Group Home

ii. Larger Facilities: In the case of residential facilities subject to § 1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

When four or more individuals unrelated to the proprietor reside in a facility, a home and community character is maintained as evidenced by:
a. each person has an individualized person centered plan;
b. the individual plan addresses individual resources or activities each person will access in the community;
c. facilities have a kitchen with cooking facilities and small dining areas;
d. individuals have access to the kitchen area to store and eat personal snacks, there are general times for meals, but an individual may eat anytime they choose.;
e. individuals assist with meal planning, preparation or shopping if this is included in their plan;
f. individuals have access to unscheduled activities in the community;
g. individuals have the opportunity to have visitors at times they prefer and at their convenience;
h. individuals are afforded privacy, are able to lock their own doors. Staff have access to key in case of emergency;
i. individuals have their own bedroom and have full access to their own personal property.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type: Group Home

Waiver Service(s) Provided in Facility: Residential Support Level I

Facility Capacity Limit: 8

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies):*

Scope of State Facility Standards

Standards Addressed
Admission policies
Physical environment
Sanitation
Safety
Staff: resident ratios
Staff training and qualifications
Staff supervision
Resident rights
Medication administration
Use of restrictive interventions
Incident reporting
Provision of or arrangement for necessary health services

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:
Facility standards address all of the topics listed.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant

Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Payment for the Participant Directed Services may be issued to legally responsible individuals for providing a service similar to personal care. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. This service is available only through participant directed opportunities and only in specified extraordinary circumstances. In order for a legally responsible individual to provide paid services the services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization. A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

The member chooses a legally responsible individual to provide this service. The member choice is documented in the client file and retained by the Case Manager. Documentation of services provided shall be submitted to the Case manager. The member/representative shall sign the employee's timesheet verifying the accuracy of the time reported. The Case Manager is responsible for monitoring service provision.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Under no circumstances may a legal guardian or an immediate family member provide traditional waiver services. Immediate family member is defined according to KRS 205.8451 as: a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild. Extended family members that are employed by an SCL provider may provide services.

For participant directed services, the Financial Management Services provider only pays for services specified in the Individual Service Plan, and case managers additionally monitor the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- Lack of a qualified provider in remote areas of the state; or
- Lack of a qualified provider who can furnish services at necessary times and places; or
- The family member or guardian has unique abilities necessary to meet the needs of the person; and
- Service must be one that the family member doesn't ordinarily provide.

In addition, in order for a legally responsible individual to provide paid services the following must also apply. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

- Services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization.
- A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

If one or more of the above specific circumstances is met for a family member to provide services, the following conditions and situations must also be met:

- Family member must have the skills, abilities, and meet provider qualifications to provide the service;
- Service delivery must be cost effective;
- The use of the family member must be age and developmentally appropriate;
- The use of the family member as a paid provider must enable the person to learn and adapt to different people and form new relationships;
- The participant must be learning skills for increased independence; and
- Having a family member as staff:

i. Truly reflects the person's wishes and desires,
ii. Increases the person's quality of life in measurable ways,
iii. Increases the person's level of independence,
iv. Increases the person's choices, and
v. Increases access to the amount of service hours for needed supports.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:
Provider enrollment is continuous and open to any willing and qualified individual or entity. A potential provider may make application by contacting provider enrollment through a toll-free phone number on the Department for Medicaid Services (DMS) website, completing the application process and obtaining an agency license or certification. These provider enrollment forms, along with new provider information are also accessible through Internet web access.
The Division of Developmental and Intellectual Disabilities (DBHDID) also has information for providers on their website and provides orientation training for new waiver providers six times a year, and potential providers are required to attend this training. Once the orientation process is complete, provider enrollment information is forwarded to the state Medicaid agency, provider enrollment branch, to complete the process of enrollment as a State Medicaid provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Percent of newly certified waiver providers that meet regulatory requirements within initial 6 months of service provision. N= All newly certified sites that meet regulatory requirements within initial 6 months of service provision D= All new certified providers

Data Source
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

Performance Measure:
Percent of enrolled waiver providers that meet regulatory requirements at certification review. N= all enrolled waiver providers that meet regulatory requirements at time of certification review D= all ongoing waiver providers

Data Source
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample** Confidence Interval = 95%

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**
	Continuously and Ongoing

Performance Measure:
Percent of waiver providers with documented plans of correction. N= Number of waiver providers reviewed by DDID for whom there are documented corrective action plans D= Number of waiver providers reviewed

Data Source

Record reviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**
	Continuously and Ongoing

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of participant directed employees who have completed required training. N=number participant directed employees who have completed required training D=total number of participant directed employee records reviewed.

Data Source (Select one):

Record reviews, off-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Less than 100% Review** **Representative Sample** Confidence Interval = 95%

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Percent of reviewed providers in which staff have successfully completed mandatory training annually. N= All reviewed providers whose staff have successfully completed mandatory training. D= Total number of reviewed providers

Data Source
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

Performance Measure:
Percent of reviewed agencies that provide case management services in which case managers have successfully completed all required case management training. N= All reviewed agencies that provide case management wherein case managers have successfully completed all required case management training D= Total number of reviewed agencies providing case management

Data Source

Record reviews, off-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Less than 100% Review** **Representative Sample** Confidence Interval = 95%

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state currently verifies that 100% of all SCL waiver providers are qualified, certified and licensed prior to rendering services. Providers who have completed the SCL new provider training/evaluation or are licensed by OIG are eligible to become Medicaid providers. The States' OIG monitors and re-licenses annually. Through the DDID SCL recertifies every two years. The state does not contract with non-licensed or non-certified providers. All State policy and procedure updates, additions, and/or changes are communicated through letters, DMS website or DDID website.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DDID performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider not meet requirements to provide services, DBHDID would recommend termination of the provider. DDID also provides technical assistance to providers.

ii. Remediation Data Aggregation
Remediation-related Data A^{gg}re^{g}ation and Anal^{y}sis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently nonoperational. **No**

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services.

Not applicable - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Participant Directed Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301 (b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals.

Case Manager (qualifications specified in Appendix C-1/C-3)

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Case management shall be conflict free in that case management shall not include provision of direct services. Agencies providing case management services to a person may not also provide other waiver services to that same person. For recipients who request an exception to this based on lack of qualified case managers in remote areas of the state or on a long standing relationship with their established case manager, DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

All Case Managers will participate in a summary rating system for case management reviews designed to reflect a point-in-time status of an individual's services related to health, safety and service issues. The primary focus is on health and safety issues but the case manager must also evaluate the appropriateness and adequacy of services.

Issues identified that are not within the funded services of this provider will not contribute to the summary rating of services for the individual. If health and safety problems are identified that are not related to the services rendered by the provider, the case manager should document the problem on the review form and refer it to the regional office for follow up even though the rating is "1" or "2 "for services provided". The provider, case manager and regional DDID team have

joint responsibility for assuring that all problems are identified and addressed.

If a person is receiving vehicle adaptations, Special Medical Equipment, Medical Supplies, Environmental Accessibility case manager notes are written to reflect that the request for service was processed and a final note to indicate acquisition and implementation of the approved service is in place.

Person Centered planning training is occurring across the state for waiver providers. Case management training is undergoing revision to educate case managers about identifying the needs of the person and locating appropriate activities that address the needs of each person. Plan of Care review will be conducted through the prior authorization process and on site monitoring and sampling of records will be reviewed at provider sites.

Information gathered from case reviews are used to develop quality improvements focused on system-wide changes, bolstering the provider's approach to reducing medical errors, which emphasizes a culture of learning, person centeredness, and accountability.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Currently, the member's Plan of Care (POC) is developed utilizing MAP 351 assessment. Kentucky will begin a phase-in of the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). The SIS includes information about the member's support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. State staff will be trained on a regional basis (dividing the state into 4 regions) as SIS interviewers. As case managers are trained, they will complete the SIS at each individual's next plan renewal date. The HRST screens for overall health risk related to disability and aging, and provides the case manager and support team with guidance in determining the person's need for further assessment and evaluation to address identified health risks. The HRST will be conducted statewide on the plan renewal date. The POC shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The POC is developed with the participation of the member and/or guardian as well as their identified circle of support. All individuals participating in the development of the POC must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The member is free to choose from the listing of available waiver providers as well as identified services.

All POC's are reviewed and requested services prior authorized through the Division of Developmental and Intellectual Disabilities (DDID). When POC's are submitted to DDID a copy of the completed assessment is included in the packet. The DDID is responsible for review of the assessment ensuring all identified needs are included and adequately addressed in the POC. If through the prior authorization process, it is determined that identified needs are not addressed in the POC, DDID will issue written notification to the case manager requiring additional information as to how these needs will be addressed.

The member's case manager is responsible for the coordination and monitoring all of the member's services including non-waiver services. The case manager shall conduct monthly face-to-face contacts to make arrangements for activities which ensure: the desires and needs of individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are coordinated; activities are documented; and plans of supports/services are reviewed at least annually and at such intervals as are indicated during planning.

The POC shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs. Any changes in the member's needs shall be identified by the case manager during the monthly face-to-face contact. All modifications to a POC shall be reviewed by DDID. All POC requirements shall be contained in the state regulation and manual governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The member's Person Centered Plan of Care (POC) is developed utilizing the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). The SIS includes information about the member's support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. The HRST screens for overall health risk related to disability and aging, and provides the case manager and support team with guidance in determining the person's need for further assessment and evaluation to address identified health risks.

The POC shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The POC is developed with the participation of the member and/or guardian as well as other service providers. All individuals participating in the development of the PCPOC must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the member regarding available waiver services and providers to meet the identified needs. The member is free to choose from the listing of available waiver providers as well as identified services.

All POC's are reviewed and requested services prior authorized through the Division of Developmental and Intellectual Disabilities (DDID). When POC's are submitted to DDID a copy of the completed assessment is included in the packet. The DDID is responsible for review of the assessment ensuring all identified needs are included and adequately addressed in the POC. Should the DDID determine identified needs are not addressed in the POC, the DDID will issue written notification to the case manager requiring additional information as to how these needs will be addressed.

The member's case manager is responsible for the coordination and monitoring all of the member's services including non-waiver services. The case manager shall conduct monthly face-to-face contacts to make arrangements for activities which ensure: the desires and needs of individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are maximized based on need; activities are documented; and plans of supports/services are reviewed at such intervals as are indicated during planning.

The POC shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs. Any changes in the member's needs shall be identified by the case manager during the monthly face-to-face contact. All modifications to a POC shall be reviewed by the DDID. All POC requirements shall be contained in the state regulation and manual governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the member are identified during the completion of the SIS and the HRST. All health, safety and welfare risks are required to be identified and addressed in the person-centered planning meeting and on the POC. Providers are required to have agency emergency plans and person specific crisis and safety plans based on individual needs. DDID reviews the submitted assessments through prior authorization process, plan of care review, on-site monitoring and sampling of plans to ensure all identified risks are appropriately addressed. If the DDID determines an identified risk has not been addressed in the POC, the DDID will issue written notification to the case manager requiring additional information as to how these risks will be addressed.
Case management training will provide education about this expectation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The member's case manager is responsible for notification of available waiver service providers. Documentation of this notification is required to be maintained within the member's chart and shall contain the member or guardian's signed acknowledgement. The case manager is responsible for assisting the member in choosing his or her providers of services specified in the POC. This assistance may include telephonic or on-site visits with members and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them of web-based provider profiles. DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441 .301(b)(1)(i):

Upon the case manager's completion of the Plan of Care (POC) it is the responsibility of the case manager to submit the POC and SIS to the Division of Developmental and Intellectual Disabilities (DDID) for review and service prior authorization. A prior authorization shall not be issued without DDID review and approval. The state Medicaid agency completes second line monitoring of a 20% sample of providers reviewed by DDID.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every twelve months or more frequently when necessary

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following:

Case manager

Appendix D: Participant-Centered Planning and Service Delivery
D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case manager for the person receiving SCL funding is responsible for the coordination and monitoring of all of the person's services including non-waiver and non-paid supports. If the person chooses to participant direct services, the case manager is responsible for ensuring the person is enrolled in and educated about the Participant Directed Option and has a free and informed choice of a Community Guide. Case managers facilitate the development of the Person Centered Plan of Care (POC) and they monitor the delivery of supports to ensure that waiver services are furnished in accordance with the POC, meet the needs of the person, and achieve their intended outcomes. Case managers conduct monthly face-to-face visits with SCL person and make monthly contacts with each chosen SCL provider to ensure: the desires and needs of the person are determined; the supports and services desired and needed by the person are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health, safety, and welfare of the person are monitored; activities and services are documented; and support strategies are reviewed at such intervals as are indicated during planning. The case manager is responsible for ensuring the waiver person makes a free and informed choice of providers, services, and resources. It is the responsibility of the case manager to provide detailed information to the person regarding available services and providers, whether those are waiver services, health services, or natural community resources to meet needs identified by the current MAP 351 assessment tool, or the Supports Intensity Scale (SIS), the Health Risk Assessment Tool (HRST); and the person centered planning process. For people who choose to participant direct services, the case manager is responsible for ensuring health, safety, and welfare of the recipient and for ensuring the effectiveness of the back-up plan. The Case Manager will communicate with the participant, representative, and the person's team as needed.

Case managers are responsible for ensuring services provided meet the person's needs. If services are not meeting the needs of the waiver person, the case manager is responsible for working with the person's support team to ensure different or additional supports are identified and provided and that a Person Centered Plan of Care modification is submitted for prior approval within fourteen (14) days of the effective date that the change occurs.

Case managers are required to document findings from their monthly visits and monitoring in a monthly summary note which is maintained by the agency in the person's record. If issues related to health, safety and welfare, services, or satisfaction are noted, the case manager is responsible for prompt follow up toward resolution or remediation. For persons who choose to direct their own services, the Case Manager is responsible for ensuring health, safety, and welfare. The Case Manager will communicate with the participant, representative, and the person's team as needed. In addition to the on-going monitoring of POC implementation that is conducted by the case manager, the following strategies are employed.

All providers of SCL services are required to establish policies concerning the health, safety, and welfare of the person supported by the agency. Additionally, providers of SCL services are required to document progression, regression, or maintenance of outcomes identified in the POC. Agencies, policies, and documentation records are reviewed at least annually by DDID to ensure compliance with these requirements. If deficiencies are noted, a plan of correction is required.

Positive Behavior Support Plans are reviewed by a Behavior Intervention Committee (BIC) prior to implementation and monitored at least annually to assess technical adequacy and appropriateness of the service. Right restrictions are reviewed by a Human Rights Committee (HRC) prior to implementation and monitored at least annually. HRC and BICs will be established regionally and minutes reviewed by DDID.

All Person Centered Plans of Care are submitted to DDID for prior approval. If information is insufficient or the plan is inadequate, notification is provided to the case manager who then has fourteen (14) days to respond in writing with additional information.

A random sample of records of people receiving waiver funding including case management notes are reviewed by DDID during certification reviews. Issues identified are either addressed through technical assistance and follow up or by citation requiring a plan of correction. The state Medicaid agency also performs second line monitoring of a 20% sample of providers reviewed by DDID. All certification reviews completed by DDID are submitted to the Medicaid agency.

Health, safety, and welfare issues are monitored by DDID through a risk management process in which serious and grave incidents are reported directly to and reviewed by DDID staff. Additionally, minor incidents are reviewed on-site by DDID field staff. Issues identified are addressed through technical assistance and follow up, investigation, and/or citations requiring a plan of correction.

All findings regarding the implementation of the POC including health, safety, and welfare, are expected to be addressed by the supporting agency. If citations are issued, the agency has 45 days from the receipt of the findings report to submit a plan of correction that addresses both the specific individual issue and the systemic issue that resulted in the citation. Acceptable plans of correction are monitored by DDID field staff to ensure implementation and effectiveness. Upon completion of all investigations, findings reports are prepared and sent to the provider and State Medicaid Agency is copied on all correspondence with a recommendation that any indication of fraud or abuse is forwarded to the Office of Inspector General or Attorney General for further review.
Furthermore, the National Core Indicators (NCI) is used to determine overall satisfaction with services. Results from the NCI are used to direct DDID's continuous quality improvement process.

b. Monitoring Safeguards.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

Case management shall be conflict free in that case management shall not include provision of direct services. Agencies providing case management services to a person may not also provide other waiver services to that same person. For recipients who request an exception to this based on lack of qualified case managers in remote areas of the state or on a long standing relationship with their established case manager, DDID will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

All Case Managers will participate in a summary rating system for case management reviews designed to reflect a point-in-time status of an individual's services related to health, safety and service issues. The primary focus is on health and safety issues but the case manager must also evaluate the appropriateness and adequacy of services. To some extent, deficiencies should be considered relative to an individual's strengths and needs. While it is recognized that the absence of deficiencies does not equate to quality in services, assurance of individuals' health and safety is an essential component of program quality. The state's first responsibility is to assure the health and safety of individuals receiving state services. The process of conducting routine individual reviews is of prime importance in assuring health and safety through the identification and correction of problems in health, safety and services for any individual.
Issues identified that are not within the funded services of this provider will not contribute to the summary rating of services for the individual. If health and safety problems are identified that are not related to the services rendered by the provider, the case manager should document the problem on the review form and refer it to the regional office for follow up even though the rating is "1" or "2 "for services provided". The provider, case manager and regional DDID team have joint responsibility for assuring that all problems are identified and addressed.
If a person is receiving vehicle adaptations, Special Medical Equipment, Medical Supplies, Environmental Accessibility notes are written until services are in place.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Percent of service plans in which services and supports align with assessed needs. N= Total number of service plans reviewed that reflect assessed needs and preferences D= Total number of service plans reviewed

Data Source
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	
Other: QIO		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

Performance Measure:
Percent of services plans that reflect individual goals and preferences N= Total number of service plans reviewed that reflect individual goals and preferences D= All service plans reviewed

Data Source
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

Performance Measure:

Percent of service plans reviewed that include a risk assessment. N=Total number of service plans reviewed that include a risk assessment D = All service plans reviewed

Data Source (Select one): **Record reviews, on-site**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

Performance Measure:

Percent of participants surveyed who said that their case manager gets them what they need as indicated on National Core Indicators (NCI). N= All respondents who said that there case manager gets them what they need per NCI data D= All participants who responded to that question.

Data Source (Select one): **Record reviews, on-site**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Operating Agency	Annually

Performance Measure:
Percent of families who are satisfied with the services and supports their family member currently receives as indicated on National Core Indicators (NCI). N=All family members who stated that their family member always/almost always gets what he or she need per NCI data D= All survey respondents to that question

Data Source:
Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Operating Agency	Annually

Performance Measure: Percent of service plans reviewed with a risk assessment that have appropriate risk mitigation. N-number of plans reviewed with risk assessment that have appropriate risk mitigation. D-number of plans reviewed with risk assessment.

Data Source: Record reviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Operating Agency	Annually

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of providers that are in compliance with waiver service plan requirements. N= All monitored sites that have 100% compliance with waiver service plan requirements. D= All sites monitored during the year.

Data Source (Select one): **Record reviews, on site**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	
Other: QIO		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

Performance Measure:
Percent of service plans that are based on "what is important to and important for" the person. N= Number of service plans that are based on "what is important to and important for" the person. D= Total Number of service plans reviewed.

Data Source (Select one): **Record reviews, on-site**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Percent of service plans indicating appropriate change in service related to documented change in participants needs within the year. N= Total number of person centered plans that were revised to address needed changes. D= Total number of person centered plans reviewed with evidence of change needed.

Data Source (Select one):
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
The percent of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan. N-the number of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person centered plan. D-total number of records reviewed.

Data Source:
Record reviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Representative Sample with 95% Confidence Interval**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
Operating Agency	Annually

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:

Percent of participants/guardians who have signed the service plan signature page indicating they were given choice of providers. N= Percent of participants/guardians who have signed the service plan signature page indicating they were given choice of providers. D= Total number of service plans reviewed.

Data Source:

On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
If the QIO determines an identified risk noted on the assessment has not been addressed on the POC, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed.
DMS performs an annual second(2nd) line monitoring of a random sample of enrolled active SCL waiver providers. Monitoring the POC includes ensuring all needs are met by appropriate interventions with specific goals and outcomes. If services are not appropriate, DMS will request in the report that a corrective action plan is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation.
A follow-up survey/review will be performed after DMS' acceptance of the provider's corrective action plan to determine whether it has been implemented.
The DBHDID submits a report to DMS which includes which member's chart was reviewed and if the submission of the forms and the services requested were appropriate. If services are not appropriate, DBHDID may reflect in the report that a Corrective Action Plan (CAP) is needed. The enrolled provider submits a CAP with supporting evidence of the implementation of the corrective action.

DMS performs a second (2nd) line monitoring which ensures DBHDID is performing monitoring according to the guidelines of the contract.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Identified individual problems are researched and addressed by the Medicaid Division Director and Medicaid staff. This may involve Medicaid staff to conduct an on-site agency review, and/or a home visit with the waiver member and caregivers. Issues may require policy clarification.
The State receives a utilization management report showing the number of service plans received, the number returned for lack of information, the number of service plans corrected and returned in a timely manner, the number not turned in timely and the responsible provider. DMS is able to request corrective action plans and recoupment of paid claims from the provider. DMS is able to request corrective action plans from the QIO if a service plan is approved, but does not meet requirements and is found during the 2nd line monitoring provided by DMS.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
State Medicaid Agency	Annually
Operating Agency	Continuously and Ongoing
QIO	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Responsible parties will be QIO and DMS.
Plan to transition plan of care and prior authorization of services from QIO to state operating agency, DDID within the second year of the waiver.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested*:*

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Supports for Community Living (S CL) waiver program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. SCL participants have the opportunity to direct some or all of their non-residential, non-medical waiver services. Traditional service delivery methods are available for participants who decide not to direct their services. Case managers provide assistance for informed decision-making by individuals and their families/representatives about the election of participant direction with information and training on the roles, risks, and responsibilities assumed by those who choose participant direction. The following entities will provide supports to participants choosing to direct their own services:

- Case Management agencies will be independent of service delivery. Case Managers will assist with the development of a circle of support, plan development, and resource development.
- The Community Guide will provide direct assistance to the participant in brokering community resources and directing their services. This can include assistance with inclusion, recruiting employees, and plan development. Community Guide is an optional service.
- Financial Management Services agency will manage the budget, ensure wage and hour laws are met, and issue checks for services authorized in the Plan of Care.
- Participants can choose agencies who will train and support qualified staff for services of the person’s choosing.
- Participants can hire their own employees that meet qualifications. If needed, the case manager or community guide will assist the participant in recruiting alternate or additional providers.

Kentucky’s participant-directed option is based on the principles of Self-Determination and Person Centered thinking. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

The principles and tools of Self-Determination are used to assist people in the creation of meaningful, culturally appropriate lives embedded in our communities and suffused with real relationships. These principles are Freedom, Responsibility, Authority, Support, and Confirmation. Tools include Community Guide, Financial Management Services, and Individualized Budgets, which will be developed annually based on assessments and the Person-Centered plan of care.

Supports that facilitate independence include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living as such as bathing, eating, dressing, personal hygiene, shopping and the use of money; reminding, observing, and/or monitoring of medications; respite; socialization, relationship building, leisure choice and participation in generic community activities.

For participant directed services, the Financial Management Services provider only pays for services specified in the Individual Service Plan, and case managers additionally monitor the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- Lack of a qualified provider in remote areas of the state; or
- Lack of a qualified provider who can furnish services at necessary times and places; or
- The family member or guardian has unique abilities necessary to meet the needs of the person; and
- Service must be one that the family member doesn't ordinarily provide.

In addition, in order for a legally responsible individual to provide paid services the following must also apply. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

- Services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization.
- A legally responsible individual shall not be approved to provide more than forty (40) hours per week of paid services.

If one or more of the above specific circumstances is met for a family member to provide services, the following conditions and situations must also be met:

- Family member must have the skills, abilities, and meet provider qualifications to provide the service;
- Service delivery must be cost effective;
- The use of the family member must be age and developmentally appropriate;
- The use of the family member as a paid provider must enable the person to learn and adapt to different people and form new relationships;
- The participant must be learning skills for increased independence; and
- Having a family member as staff:

i. Truly reflects the person's wishes and desires,
ii. Increases the person's quality of life in measurable ways,
iii. Increases the person's level of independence,
iv. Increases the person's choices, and
v. Increases access to the amount of service hours for needed supports.

All participants are afforded the opportunity to direct all non-residential, non-medical waiver services as long as provider qualifications and background checks as defined in waiver regulations are met. A member may receive a combination of participant directed and traditional waiver services. Services shall be prior authorized and payment for these services shall not exceed the member's budget as established by the Department for Developmental and Intellectual Disabilities.

The case manager is responsible for educating members regarding participant directed opportunities. Case managers meet with members to detail the participant directed service options; provide guidance regarding community guide services, which will assist with employee recruitment and hiring procedures; develop the new Plan of Care to include participant directed services; establish the member's budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly face-to-face contact is required between the case manager and the member and member's representative (if applicable) to ensure the member's needs are being met in an appropriate manner and monitor health, safety and welfare. Community Guides will meet with members as needed.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Both Authorities. The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement

- ✓ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ✓ **Participant direction opportunities are available to participants who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four person unrelated to the proprietor.**

Appendix E: Participant Direction of Services

E-1: Overview

d. Election of Participant Direction. Election of participant direction is subject to the following policy

The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct services.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case managers will be required to provide information about participant direction opportunities to the participants at the time of initial Plan of Care, at least annually thereafter, and at any point of recipient or guardian inquiry. Case managers will complete the person centered Plan of Care, and provide detailed information regarding the participant direction opportunities available through the waiver program. The case manager will be responsible for explaining the recipient's responsibilities related to participant direction opportunities.

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative:

The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A non-legal representative may be freely chosen by an adult waiver recipient to direct waiver services. This representative may not be hired as an employee to provide any of the participant-directed waiver services. The Representative shall act in accordance with the needs and preferences of the participant, as documented in the SIS and the person centered planning process. The case manager will be responsible for monitoring the member's Plan of Care (POC) and ensuring needed services are being appropriately provided to the recipient. The Case Manager will ensure that services are carried out accordingly and that the participant remains satisfied with services over time.

Appendix E: Participant Direction of Services

E-1: Overview

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Environmental Accessibility Adaptation Services	✓	
Supported Employment	✓	
Community Guide	✓	✓
Goods and Services	✓	
Community Access	✓	✓
Respite	✓	✓
Personal Assistance	✓	✓
Day Training	✓	
Shared Living	✓	
Transportation	✓	
Natural Supports Training	✓	
Vehicle Adaptation	✓	

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant.

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services.

Private entities

i. Provision of Financial Management Services.

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services will be provided by a single vendor fiscal agent obtained through an RFP. The agent will contract with the Department for Medicaid Services (DMS).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS entities are compensated through their contracts with DMS. The Department for Medicaid Services (DMS) will compensate the agent an administrative fee per member utilizing participant directed opportunities, per month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide

Supports furnished when the participant is the employer of direct support workers:

- ✓ Assists participants in verifying support worker citizenship status
- ✓ Collects and processes timesheets of support workers
- ✓ Processes payroll, withholding, filing, and payment of applicable federal, state, and local employment-related taxes and insurance

Supports furnished when the participant exercises budget authority:

- ✓ Maintains a separate account for each participant's participant-directed budget
- ✓ Tracks and reports participant funds, disbursements, and the balance of participant funds
- ✓ Processes and pays invoices for goods and services approved in the service plan
- ✓ Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Additional functions/activities:

- ✓ Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ✓ Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

All financial management services entities are subject to an annual on-site review by DMS. This review shall include audits of submitted timesheets and supporting documentation against any payments issued to employees by the FMS. The audit shall identify any deficiencies and require a corrective action plan from the FMS. Participant satisfaction surveys shall be conducted annually (at a minimum) and those survey results will be utilized to address and resolve FMS issues.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested.

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager is responsible for educating members regarding participant directed opportunities. Case managers meet with members to detail the participant directed service options; develop the new Plan of Care to include participant directed services; establish the member's budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly face-to-face contact is required between the case manager and the member and member's representative (if applicable) to ensure the member's needs are being met in an appropriate manner and monitor health, safety and welfare.

Waiver Service Coverage. Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	✓
Community Guide	✓

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A person may voluntarily dis-enroll from the participant direction opportunities at any time. The case manager shall assist the member and/or guardian prior to day of the termination to assist the person in locating traditional waiver service providers of their choice. Participant Direction is not terminated until the traditional service agency is ready to provide services. To ensure continuity of services within one business day, the Case Manager will coordinate the completion of the required documentation to ensure there is no lapse in service.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The plan of care and service provision will be continually monitored by the case manager. Should monitoring activities reflect the person's health and safety is being jeopardized the case manager shall begin immediate involuntary termination from the participant direction opportunities. At this time the case manager should immediately begin assisting the member and/or guardian in securing traditional waiver services through a provider of their choosing. If these monitoring activities reflect the member's needs are not being met in accordance with the approved Plan of Care (POC) or the funds in the individualized budget are not being utilized according to program criteria, the case manager will work with the consumer or the designated representative to resolve the issues and develop a corrective action plan. The case manager will monitor the progress of the corrective action plan and resulting outcomes to resolve the issue. If the person is unable to resolve the issue, unable to develop and implement a corrective action plan or unwilling to designate a representative within ninety (90) days of identification of the issue the case manager will proceed with involuntary termination procedures. The case manager shall document the reason for the termination, actions taken to assist the person to develop a prevention plan and the outcomes. The case manager shall begin to assist the member and/or guardian within one (1) business day of the termination to assist the person in locating traditional waiver service providers of their choice.
Participant Direction is not terminated until the traditional service agency is ready to provide services. To ensure continuity of services within one business day, the Case Manager will coordinate the completion of the required documentation to ensure there is no lapse in service.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		96
Year 2		126
Year 3		156
Year 4		186
Year 5		216

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ✓ **Recruit staff**
- ✓ **Hire staff common law employer**
- ✓ **Specify additional qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3**
- ✓ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3**
- ✓ **Determine staff wages and benefits subject to State limits**
- ✓ **Schedule staff**
- ✓ **Orient and instruct staff in duties**
- ✓ **Supervise staff**
- ✓ **Evaluate staff performance**
- ✓ **Verify time worked by staff and approve time sheets**
- ✓ **Discharge staff (common law employer)**

b.Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. *When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget.*

- ✓ **Determine the amount paid for services within the State's established limits**
- ✓ **Schedule the provision of services**
- ✓ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ✓ **Identify service providers and refer for provider enrollment**

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Division of Developmental and Intellectual Disabilities (DDID) shall establish an individualized, flexible budget annually based on needs as identified in the Supports Intensity Scale (SIS), Health Risk Screening Tool (HRST), and the Person-Centered plan of care. The budget can be adjusted as needs change. The participant may negotiate wage rates with employees however the hourly rate shall not exceed the rate reimbursed to traditional waiver providers for a similar service.
The methodology for establishing the budget is included in the program regulation, which is subject to public comment when promulgated or amended and is always available for public review.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

At the time the case manager conducts the face-to-face visit to develop the participant's Plan of Care (POC); the participant-directed budget is developed based on needs identified. If the participants' circumstances change, the case manager can request a new assessment of the participant's needs for determining an adjustment to the budget. Budget adjustments are submitted to and approved by DBHDID within 14 business days. The participant is notified via letter and through case manager of the opportunity of a fair hearing in response to the denial of a budget adjustment.

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility.

Modifications to the participant directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The case manager, community guide (if applicable) and financial management services (FMS) entity shall continually monitor expenditures for each member. Monthly reports shall be provided to the operating agency and the Department for Medicaid Services (DMS) outlining member budget activity. Should a member be identified as prematurely depleting their budget, the case manager shall contact the member and/or representative and conduct a face-to-face visit to discuss this issue. The case manager shall assist the member and/or representative in development and implementation of a corrective action plan to avoid complete depletion of the established budget prior to allocation of the next budget. If services are insufficient and budget is depleted, the case manager will assist the participant in completing a budget exception request. The member and/or representative and case manager shall monitor the progress of achieving the goals outlined in the corrective action plan as often as necessary to obtain compliance. It is the responsibility of the case manager to ensure the member is made aware of the implications of underutilization of their budgets.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals who are denied level of care, budget adjustment, suspension, reduction or termination of services are issued written notification of appeal rights at the time of denial. These rights are contained as a part of the denial notices. All appeal rights are outlined in 907 KAR 1:563, "Medicaid Covered Services Hearings and Appeals" which requires written notification of appeal rights to

the member and the continuation of waiver services if the appeal is requested within ten (10) calendar days of the date of the notification. The notices are generated electronically at the time of denial.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing.

Yes. The State operates an additional dispute resolution process

Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DMS provides for a reconsideration process that is operated currently by the QIO and will be transitioned during year two of the waiver to the state operating agency, DDID. The provider, recipient or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care. A written request for reconsideration must be postmarked or submitted to the QIO or DDID via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. A denial may be overturned, upheld, or modified as a result of reconsideration. If the denial is not overturned or if the request for reconsideration is past the ten (10) day time frame, then the recipient can appeal the denial through the Medicaid appeal process and request an Administrative Hearing. The process is as follows:

1. The provider, recipient, or guardian acting on behalf of the recipient may file a reconsideration request up on receipt of written notice of a denial of services or level of care.

2. A written request for reconsideration must be postmarked or submitted to the QIO or DDID via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time-stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. As a result, an out of time frame letter will be generated that indicates that the request for reconsideration was untimely and not valid.

3. The QIO or DDID will conduct the reconsideration and render a determination within three (3) calendar days of the request.

4. Within two (2) business days of the reconsideration determination, a letter communicating the decision will be mailed to the recipient (or his/her guardian), attending physician, and provider.

A denial may be overturned, upheld, or modified as a result of a reconsideration.

– If the reconsideration determination upholds the original decision to deny service(s) or level of care, the recipient, his/her legal guardian, or his/her representative (authorized in writing) may request an administrative hearing. Administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services. For individuals who have a certified level of care and who are receiving services, DMS will pay for continuation of those services through the date a final decision is made, provided that the hearing request is submitted within the specified time frame.

– If the reconsideration determination overturns the original decision, a prior authorization will be issued.

– If the reconsideration determination modifies a portion of the original decision, the portion of the decision that remains denied may be further disputed by the recipient, his/her legal guardian, or his/her representative (authorized in writing) through an administrative hearing. For the portion of the decision that overturns the original decision, a prior authorization will be issued.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System.

Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The grievance/complaint system shall be operated by the Department for Behavioral Health, Developmental and Intellectual Disabilities for certified providers and the Office of the Inspector General (OIG) for Home Health Agencies and Adult Day Health Care Centers that provide services for the HCBS waiver.

b. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver members may register any grievance/complaint regarding a waiver service provision or service providers. The member may contact DMS, or DBHDID who will enter the complaint into a tracking database. The agency will immediately assess the gravity of the grievance/complaint. If a member's health, safety and welfare are in jeopardy, the agency will immediately respond. Other complaints/grievances shall be addressed within five (5) business days. All complaints/grievances are tracked and trended to identify if additional provider trainings should be developed and conducted.

In addition to the agencies grievance/complaint system, each waiver provider shall implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. The provider grievance and appeals are monitored through on-site surveys, investigations and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.

Yes. The State operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The current system has a Class I, Class II, and Class III reporting process. This process is now undergoing changes from three classifications, to only 2 types of incidents: All individuals/entities providing services shall submit notification by fax or phone notification of incidents and critical incidents according to the following requirements:

Incident: Any occurrence that impacts the health, safety, welfare, or lifestyle choices of an individual. Incidents are minor injuries, medication errors without any serious outcomes, behaviors or types of situations that do not meet the definition of a Critical Incident.

•Incidents shall be:
a.Maintained on prescribed form in the record at the provider site.
b.Immediately assessed for potential abuse, neglect and/or exploitation. If assessment is positive for potential abuse, neglect and/or exploitation, incident must be immediately redefined as a Critical Incident and reported to the Department for Community Based Services. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual. Redefined incidents must follow procedures for Critical Incident.

c.Reported to the individual's Case Manager and/or guardian within twenty-four (24) hours of the discovery of the incident.
d.Recorded by the discovery agency staff on an incident report form.

Critical Incidents: An alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to the individual.

Abuse, neglect, and exploitation as defined by KRS Chaper 209: "Abuse" means the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.

"Neglect" means a situation in which an adult is unable to perform or obtain for himself or herself the goods or services that are necessary to maintain his or her health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult;

"Exploitation" means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources;

Critical Incidents also include, but are not limited to:
–Death

–Homicidal/Suicidal Ideation

–Missing person: An incident not considered neglect and the individual cannot be located for a period of time longer than specified in the person centered plan and crisis prevention plan and the individual cannot be located after actions specified are taken; or circumstances indicate that the individual may be in immediate jeopardy; or law enforcement has been called to assist in the search for the individual.

–Loss of limb

Critical Incidents shall be:
Maintained on prescribed form in the record at the provider site.
Immediately reported to Department for Community Based Services, Adult Protective Services, the case manager, and guardian by person discovering the critical incident if the potential for abuse, neglect and/or exploitation is suspected. Person discovering the incident must take immediate action to ensure the health, safety, and welfare of the at-risk individual. If not potential abuse, neglect, or exploitation, reported to the individual's case manager, guardian and DDID Regional nurse within eight (8) hours of the discovery of the critical incident.
Recorded by the discovery agency staff on a critical incident report form. Report must include:
i. Identifying Information.
ii. Details of the Incident.
iii. Relevant Consumer Information including, but not limited to:
1. Axis I Diagnoses
2. Axis II Diagnoses
3. Axis II Diagnoses
4. Listing of Recent Medical Concerns
iv. Analysis of Causal Factors

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDID provides on-line training for providers regarding the statutory and regulatory reporting requirements and identification and prevention of abuse, neglect and exploitation. This training is available online through the College of Direct Support. SCL Providers are required to educate all consumers at least annually and more often as needed, regarding recognition of abuse, neglect, and exploitation and the process to report same. Training is tailored to each indivdual's learning style and can be provided in a variety of formats either on line or face to face. Each provider is required to assist and support the consumer's ability to communicate freely with family members, guardians, friends, and case managers. For consumers who choose to direct their own services, it is the responsibility of the case manager to ensure that the consumer and all employees are trained on abuse, neglect and exploitation and reporting requirements.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G- 1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical events/incidents are received by the DDID regional nurse and a follow-up assignment is generated through the risk management system. Assignments involving immediate health, safety or welfare concerns require on-site follow-up immediately to ensure safety. A report of issues causing concern is due within 48 hours of assessment. Assignments not involving immediate health, safety, or welfare concerns require follow-up within 20 calendar days. Follow-up reports are documented in the Risk Management database. If the issue cannot be effectively addressed through standard follow-up procedures, an investigation is initiated by the Risk Management Supervisor. Investigations may be conducted as desk level or on-site; depending on the nature of the complaint or incident. Investigation assignment is made by Risk Management Supervisor using the database. Investigator assigned will make contact with DCBS to coordinate investigation activities. The investigation and written report are to be completed within 45 calendar days. The investigator periodically consults with the Risk Management Supervisor regarding the status of the investigation. If the investigation report results in documentation of regulatory noncompliance, a findings letter including citations is generated and forwarded to the provider agency. All completed investigations are sent to DMS for review.

There are the same reporting requirements when individuals choose to direct any or all of their services.

Incidents are:
Reviewed by the Case Manager on a monthly basis to determine if appropriate remediation occurred.

Reviewed by agency staff on a quarterly basis to analyze data on trends or patterns, agency performance and remediation as documented in the agency's quality improvement plan.

Critical Incidents are:
Reviewed by Case Manager on a monthly basis to determine appropriate remediation occurred.
Reviewed by agency staff on a quarterly basis to analyze data on trends or patterns, agency performance and remediation as documented in the agency's quality improvement plan.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

A Memorandum of Agreement between the Department for Community Based Services (DCBS), the Department for Medicaid Services and the Department for Behavioral Health, Developmental and Intellectual Disabilities includes reporting and conducting collaborative investigations when incidents of abuse, neglect or exploitation occur when participants are enrolled in the SCL waiver.

Upon receipt of incident notifications and/or final reports each incident is immediately screened to ensure that the provider agency has taken appropriate steps to ensure the health, safety, and welfare of the individual(s) involved. If concerns are identified the issue(s) are referred to a DDID regional staff member for immediate follow-up. Following the health, safety, and welfare screening, all incident reports are screened for the appropriateness of provider analysis and reaction.
When questions arise that make effective evaluation of the provider's activities impossible, provider staff members are contacted for immediate clarification.

Concerns that do not put individuals at needless risk are referred to the DDID regional staff member responsible for providing technical assistance to the provider for in-depth follow-up during their next scheduled technical assistance visit with the provider.

All complaints received by DDID are followed up by appropriate DDID staff members.

If at any point during the process it is determined that the follow-up of an incident or complaint is complex, the incident or complaint is assigned to a certified investigator for on-site or desk level investigation. All findings require the submission of an acceptable corrective action plan that is monitored by DDID field staff for effectiveness. As the oversight of this process moves towards utilizing a web-based system, accessed at all levels (local, regional, and state), the processes will become more streamlined and efficient:

For Incidents:
Audited through random sample process by regional nurse monthly or more frequently for health, safety and welfare of individual to:
o Ensure that necessary notifications have been made;
o Coordinate follow-up and technical assistance with additional DDID staff as necessary;
o Make referrals for investigations when needed.

Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process in support of person centered planning and individual's satisfaction with their health, safety and welfare needs.

Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality

Improvement process related to agency certification surveys, investigations, monitoring and technical assistance. For Critical Incidents:

Audited through random sample process by regional nurse monthly or more frequently for health, safety and welfare of individual to:
o Ensure that necessary notifications have been made;
o Coordinate follow-up and technical assistance with additional DDID staff as necessary;
o Make referrals for investigations when needed.
o
Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process in support of person centered planning and individual's satisfaction with their health, safety and welfare needs.
Audited through random sample by DDID staff regionally and at Central Office as part of the Continuous Quality Improvement process related to agency certification surveys, investigations, monitoring and technical assistance.

All completed investigations shall be sent to DMS for review.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion.

The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

DDID recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

DDID is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a crisis prevention plan and a WRAP plan if indicated.

The state operating agency-DDID, is responsbible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, complaints. The continuous quality improvement process will reveal trends, oatterns and remediation necessary to ensure proper implementation of plan of care and participant safety.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

b. Use of Restrictive Interventions. *(Select one):*

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

iii. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be reviewed and approved on an annual basis by a Human Rights Committee that is organized by provider agencies with DDID oversight. State laws, regulations, and policies related to use of restrictive interventions will be made available to CMS upon request through the Medicaid agency or the operating agency.

When an individual's circle of support believes that a right restriction is necessary to maintain health, safety and welfare, the rights restriction must be reviewed and approved by a Human Rights Committee (HRC). The HRC must review sound documentation that less restrictive attempts to teach and support the individual to make an informed choice are not effective. The rights restriction must include a plan to restore the individual's rights and should be reviewed on at least an annual basis.

Utilization of restrictive interventions is monitored as part of individual critical incident review conducted by Regional Nurses in addition to monitoring of incident data trends on each of the following levels: participant, provider, regionally and statewide.

DDID staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. Through this process, DDID can determine that technical assistance may be needed. This assistance may be provided in a variety of ways, as best suited to the identified issue, to include sharing of information, formal training event or consultation by DDID staff.

Restrictive measures prohibited include witholding of food or hydration as a means to control or impose calm; access to a legal advocate or ombudsman; access to toilet, bath or shower; deprivation of medical attention or prescribed medications; deprivation of sleep; access to personal belongings; and access to natural supports.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into a crisis prevention plan.

A chemical restraint is the use of a medication either over the counter or prescribed, to control behavior, restrict movement, or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis. The use of chemical restraint is never acceptable.

Utilization of restrictive interventions is monitored as part of individual critical incident review conducted by Regional Nurses in addition to monitoring of incident data trends on each of the following levels: participant, provider, regionally and statewide.

DDID staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. Through this process, DDID can determine that technical assistance may be needed. This assistance may be provided in a variety of ways, as best suited to the identified issue, to include sharing of information, formal training event or consultation by DDID staff.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The operating agency, DIDD, is responsible for monitoring and overseeing the use of restrictive interventions. At a minimum, rights restrictions are reviewed by DDID staff members during the provider's certification process. In addition, human rights restrictions are reviewed by risk management through the incident and complaint process. Issues found with rights restrictions through this screening process are referred to DDID field staff to provide intervention.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

Applicability: Yes. This Appendix applies *(complete the remaining items)*

a . Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Each SCL certified provider agency is required by the regulation to have policies in place specific to medication management and administration to ensure the health, safety, and welfare of the individual's they support.

Provider agencies receive technical assistance from DDID field staff to utilize Best Practice when providing supports. Individuals may choose multiple agency's to provide their waiver services. The monitoring of their medication administration can be conducted by multiple staff, who have met all training requirements as set forth in the SCL regulations, at each agency.

The second line/ongoing monitoring of the individual's medication regimes in the Waiver, is the responsibility of the administration, management, and quality assurance staff at the SCL certified agency to include the case manager, registered nurse, program director, quality manager, incident manager, contracted pharmacist, and positive behavioral specialist.

While some monitoring responsibilities may overlap, the scope, focus, or extent by which any of the identified person's can provide the monitoring of medication management is determined by their credentials.

Focus areas would include reviewing for poly pharmacy usage, follow up with doctor appointments and prescriptions, review of laboratory values, overall health, appearance, and affect, an individual's compliance with their medications, staff competency of medication administration, documentation of medical diagnosis and need for the medication, medication reduction plans, reaction and interaction with other meds, documentation of need and effectiveness of PRN medications, due process, timely reordering of medications; staff training, reporting medication errors correctly, compliance with state and federal laws, and agency quality improvement measures.

Monitoring can be conducted by direct observation, assessment, and interview of the individuals' and/or by reviewing MAR's, PRN reports, incident reports, laboratory reports, doctor's orders, medication error reports, actual pill counts, appropriate behavior support plan implementation, daily notes, individual's health status, review of health logs and interviews with direct support staff.

SCL provider agency specific policies describe the frequency of monitoring. Based on regulatory reporting requirements monitoring of medication administration is done at least monthly. However, more frequent monitoring may occur as part of the agency's quality improvement process or based on the individual's support needs.

Each agency is required by the regulation to have quality improvement policies.

This includes methods for tracking and trending issues and incidents. When reoccurring incidents or potentially harmful practices are identified, the agency must implement measures to prevent them from happening, this may include, personnel reassignments, training/education, policy or system changes, and updates to the plans of care. When routine behavior modification medications are used, the agency ensures monitoring of the medication management and administration by review of Axis 1 diagnosis or justification of medication if there is not an Axis I diagnosis; a review of the medication, usage, and reported need for the medication by the Human Resource Committee and the Behavior Intervention Committee with due process afforded to all individuals. If needed, a behavior support plan should be reviewed for proper implementation. PRN medication protocols should be reviewed for appropriate processes and the agencies quality improvement plan should reflect all necessary changes and timelines for which they should be achieved.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Through an interagency agreement with DMS, DDID is the state agency responsible for administering the SCL waiver program which includes monitoring and oversight of second-line medication management processes.

DDID Central office staff includes pharmacists and nurses who review medication practices, monitoring, and administration by the provider agency, for regulatory compliance, and best practice. SCL providers can request additional assistance as needed.

Data from assessments, incident reports and monthly medication error reports and complaints are entered into the DDID risk management database. Further development of this database system will enable DDID staff to perform trend analysis and use that information to proactively address issues with SCL providers. Technical assistance is provided by DDID staff when a potentially harmful practice is identified. If the potential hazard puts the individual in immediate risk, the DDID field staff will conduct onsite visits to monitor and evaluate the situation and provide technical assistance to the agency. The agency must provide DDID their plan to address the situation and what measures they will implement to prevent it from happening again.

c. Medication Administration by Waiver Providers

Provider Administration of Medications.

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. ***(complete the remaining items)***

i. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDID, in collaboration with the Department for Public Health and the Kentucky Board of Nursing (KBN) have developed a standardized curriculum for training medication administration to non-licensed personnel.

This course is intended for non-licensed personnel who provide direct care of individuals. Upon successful completion of this course, the non-licensed personnel would prove competency in administration of an individual's medication for those who are unable to self-administer, and when appropriate, observation of an individual's self-administration of medications.

The SCL provider agency must utilize a DDID trained RN to provide medication administration training for agency direct support staff. This is a KBN approved curriculum for staff that will administer or assist with administering medication to individuals in SCL.

Registered Nurses will train direct support professionals by direct observation, auditing medication counts, review of MAR and prescriptions, laboratory values and by monitoring the health of the individual’s supported by ensuring the 6 RIGHTS of Medication administration.

Quality assurance measures that will be utilized by DDID RN’s would include assessing staff’s ability to identify and report medication errors made by self or others, obtain emergency services when needed, and would be able to recognize and report side effects or adverse reactions to medications. DDID RN’s may audit the MAR and supporting documentation to track trends in errors, staff, times, medications, and individuals. The provider will be required to have policies in place that follow the regulation and contain agency specific protocol when retraining of staff is needed.

DDID will maintain a listing of DDID qualified RN trainers and a roster of direct support professionals who have completed the training and DDID RN’s will periodically observe the curriculum being taught while onsite at SCL provider agencies.

Self administration of medication documentation such as MAR's, medical appointment visits and individual interviews will be utilized by DDID RN staff to determine if self-administration practices are safe. Technical assistance will be provided to agency staff as needed.

ii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported to the state operating agency, DDID.

(b) Specify the types of medication errors that providers are required to *record:*

A monthly medication error reporting tool was developed to ensure a more consistent, accurate manner of identifying medication error incidents. All medication errors are documented on an approved form and maintained at the provider agency for review by DDID, case managers, DCBS and DMS.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors that meet the criteria for a critical incident shall be reported to the state operating agency- DDID and DCBS.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Through an interagency agreement with DMS, DDID is the state agency responsible for administering the SCL waiver program which includes monitoring and oversight of second-line medication management processes.

DDID has developed a computerized medication error system to manage medication error data. The development of the risk management data system has enabled DDID to perform trend analysis and use that information to proactively address issues with SCL providers.

Monitoring of medication administration and agency policy's are included when DDID field staff conducts certification reviews. All citations require a plan of correction from the SCL provider agency.

SCL providers who do not submit the monthly medication error report are required to submit a plan of correction to DDID within 30 days detailing measures to be implemented that will correct the citation.

SCL providers who receive technical assistance, but continue to have repeat occurrences of medication errors and/or classification errors, will receive citations and possible sanction recommendations by DDID. DDID will notify DMS in writing if an SCL provider does not implement the necessary processes to ensure the health, safety and welfare of the individual's they support.

DDID Central office staff includes pharmacists and nurses who review medication practices, monitoring, and administration by the provider agency, for regulatory compliance, and best practice. SCL providers can request additional assistance as needed.

DDID provides Medicaid information regarding the monitoring and oversight with copies of provider letters, certification review schedules and modifications, certification and investigation findings reports, recommendations pertaining to decertification, certification and moratorium. A variety of ad hoc reports, trend analyses, risk management data, and other requested documentation is provided to DMS as required.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Percent of critical incident reports of potential abuse that were submitted to DDID within the required timeframes. N=Number of Critical incident reports of abuse that were submitted to DDID within the required timeframes D= Total number of critical incident reports submitted

Data Source:
On-site observations, interviews, monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

Performance Measure:

Percent of participants who had at least one report of abuse, neglect or exploitation for the year. N= Number of participants who had at least one report of abuse, neglect or exploitation for the year D= Total number of participants for the year

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Continuously and Ongoing**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

Performance Measure:

Percent of participants who had an injury reported due to restraint. N=Total number of participants injured due to restraint D= Total number of restraints reported

Data Source:

Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Continuously and Ongoing**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

Performance Measure:
Percent of surveyed participants who responded on the National Core Indicator survey that they are always/sometimes afraid or scared in their home and in their neighborhoods N= Number of surveyed participants who reported they are always/sometimes afraid or scared in their home and in their neighborhoods D= Total number of survey responses

Data Source:
Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

Performance Measure:
Percent of surveyed participants who responded on the National Core Indicator survey that they had a physical examination in the last year. N= Number of surveyed participants who had a physical examination in the last year. D= Total number of survey responses

Data Source:
Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

Performance Measure:

Percent of surveyed females who responded on the National Core Indicator survey that they had an OB/GYN examination in the past year. N= Number of surveyed female participants who had an OB/GYN examination in the past year D= All female survey responses

Data Source:

Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

Performance Measure:

Percent of surveyed males who responded on the National Core Indicator survey that they had a prostate examination in the past year. N= Number of surveyed male participants who had a prostate examination in the past year D= All male survey responses

Data Source:

Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

Performance Measure:
Percent of surveyed participants who responded on the Core Indicator survey that they had a routine dental visit in the past year. N= All participants who said they have had a routine dental visit in the past year D= All survey responses

Data Source:
Analyzed collected data (including surveys, focus group, interviews, etc)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Operating Agency	**Annually**

Performance Measure:
Percent of audited providers in which direct support staff had criminal background checks prior to providing services. N= Total number of audited providers whose direct support staff had criminal backgrounds checks as required before providing services D= Total providers audited during a year

Data Source:
Record reviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
Operating Agency	**Annually**	**Less than 100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Provider agencies are licensed annually by OIG or certified by SCL at least every two years, which includes monitoring of the employee records for criminal checks and abuse registry checks.

DDID performs first line monitoring and identifies deficiencies of the SCL waiver provider and requires a corrective action plan to address the deficiencies identified. Findings are reported to DMS. During the recertification process, policy and procedures for training provider staff are reviewed and review of incident reports for the period of the review are completed to ensure health, safety and welfare.
DDID monitors the complaint process by examining the complaint logs and the results of client satisfaction surveys, National Core Indicators data. By analyzing the trends from incident database on abuse, neglect, exploitation, and injuries reported due to restraint DDID will monitor agency reporting and remediation of critical incidents both on an individual and agency levels.
Require providers to post the toll-free fraud and abuse hotline telephone number of the office inspector general for all staff, waiver participants, and their caregivers or legal representatives and other interested parties to have access to. The purpose of this hotline is to enable complaints or other concerns to be reported to the Office of the Inspector General.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DDID performs monitoring and certification of the SCL providers. Should an enrolled provider not meet requirements DMS would terminate the provider enrollment. DDID performs the first line monitoring and audit reviews. Should the auditing reveal that documentation is not present or does not support the services provided as required, DDID will recommend recoupment to DMS.

ii. Remediation Data Aggregation

Remediation-related Data A^{gg}re^{g}ation and Anal^{y}sis (includin^{g} trend identification)

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently nonoperational.

No

Appendix H: Quality Improvement Strategy

Under § 1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

During 2009, the Department of Behavioral Health, Developmental and Intellectual Disabilities adopted a new planning process. Effort was made to involve more families, advocates and consumers than ever before. Participants identified needs, recommended potential solutions to the needs, and helped decide what priorities would be the focus during the coming years. This information was compared to information obtained from the National Core Indicators (NCI) Consumer/Family Survey results which, in turn, resulted in reevaluation of the Division's Core Values and Vision to the following: People receiving support are safe, healthy and respected in their community; live in the community with effective, individualized assistance; and enjoy living and working in their community. In addition, the House Bill 144 Committee, which includes Legislators, self-advocates, family members, professionals and providers, developed a list of short and long-term goals for the Division which included initiatives focusing on workforce development, quality and best practices.

To carry this out, DDID is in the process of establishing a Continuous Quality Improvement (CQI) plan to develop comprehensive, systemic, strategic initiatives which outline collection and analysis of data, methods of prioritizing goals, and methods to evaluate effectiveness of implemented strategies.

ROLES AND RESPONSIBILITES FOR QUALITY IMPROVEMENT: While contemplating the waiver revisions, it was realized that quality improvement for the program must penetrate and guide each aspect necessary to respectfully and safely support an individual in an effective and efficient manner. All data needs to be accessible, meaningful and applicable on both a micro and macro-level to meet this goal and to truly have safeguards for participants. Regional teams will be established to monitor individual assessments results from the SIS and HRST; incidents; implementation and monitoring of satisfaction of the

individual and his or her circle of support; and delivery of timely, appropriate, effective and fiscally responsible supports. The data set shall include data from: LOC determinations; prior authorization, service and expenditure reports; individual plans and outcomes; incidents; medication error reports; monitoring visits; progress toward achieving corrective action plan goals; recertification reviews; and NCI data. The Regional Teams will utilize this information to assist providers in developing and acting on their own quality improvement initiatives while integrating expected and best practices.

DMS and DDID shall establish a CQI Committee consisting of management staff and those assigned the duties of monitoring implementation and progress of the CQI Plan. DDID CQI members shall meet quarterly with each Regional Team to review trended data related to the individual, the provider and corrective action plans. This information will be feed back to providers so that actions steps are developed and implemented. The CQI Committee shall review the aforementioned data sets and outcomes on a statewide level to include data from each region as well as data from: assurance measures, remediation, and findings and recommendations from Mortality Review and Risk Review Committees. Reports of the CQI Committee's actions shall be presented to an advisory stakeholder committee established through legislative action, the House Bill 144 Commission (HB 144). The Medicaid agency retains final oversight of the operating agency.

PROCESS FOR TRENDING: The Regional Team shall assist each provider in aggregation and analysis of data from all incidents, expenditure/service reports, prior authorization of services, monitoring and implementation of person centered plans and level of care evaluations at least quarterly but as often as needed to identify trends and generate action steps to manage identified issues. Each Regional Team will provide no less than quarterly reports of identified trends and progress on corrective action plans audited by random sample to the CQI Committee. In turn, the CQI Committee shall present findings and recommendations based on statewide data analysis and information from Risk Management and HB 144 Commission advisory committees and Mortality Review Committee at least quarterly to each Regional Team. This information will be made available for review by stakeholders through existing venues such as the Department web site, HB 144 Committee and sub-committee meetings and videoconferences.

The Division, certified providers, individuals and families participate in the National Core Indicators (NCI) Consumer Satisfaction Survey which captures data regarding participant choice and satisfaction. At the state level, the CQI committee will examine the survey results, noting trends, and integrate data from the other sources to obtain an overarching view of progress toward priorities.

PRIORITIZING: While contemplating waiver revisions, DDID reviewed provider certification data, NCI data, gathered stakeholder input and integrated information from Mortality Review Committee and the Risk Management Advisory Committee. Based upon all of the data gathered, DMS and DDID partnered in setting the following priorities with the implementation of the revised waiver: 1) Person Centered Plans are based upon an individual's assessed preferences and needs. The plans reflect both what is important for and important to the individual; 2) Case managers and direct support professionals complete required training and demonstrate skills necessary to assist an individual in attaining what is important to and for them; 3) individuals feel safe and secure in their own homes and neighborhoods and 4) Supports are delivered in a fiscally responsible and effective manner. DDID believes the data related to achieving these priorities are essential to using person centered thinking to achieve a person centered system that offers individualized supports in a holistic fashion. Noted trends from the various data sets will be coupled with NCI results and expected/best practices to establishing future priorities.

IMPLEMENTATION OF SYSTEM IMPROVEMENTS
Quality Improvement strategies will be implemented at various levels as guided by data trends to include individual level; provider level; regional level; over more than one region when indicated; and
statewide. Progress toward achieving outcomes shall be monitored at these levels as well with data flowing through CQI cycle. Any training needed to assist with strategy implementation may be held face-to-face, videoconferencing or online learning modules.

ii. S^{y}stem Im^{p}rovement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Other** As needed.
Other QIO	

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Mortality Review Committee consists of the Clinical Director, DDID Nurse Administrator, Department pharmacist, and a consulting psychiatrist. This committee reviews all incidents of deaths reported to the Department including investigations and remediation. From those findings, recommendations will be sent forward to the CQI committee.

The Risk Management Advisory Committee consists of the Clinical Director, DDID Nurse Administrator, Department incident management coordinator, Department pharmacists, facility coordinators, as well as representatives from IT. This committee reviews incident data, trends and monitors progress of ensuring health, safety and respect, and provides feedback and recommendations to CQI committee.

Regional teams will be established to monitor individual assessments results from the SIS and HRST; all incidents; implementation and monitoring of person centered plans by skilled staff; satisfaction of the individual and his or her circle of support; and delivery of timely, appropriate, effective and fiscally responsible supports. The data set shall include data from: LOC determinations; prior authorization, service and expenditure reports; individual plans and outcomes; incidents; medication error reports; monitoring visits; progress toward achieving corrective action plan goals; recertification reviews; and NCI data.

The CQI Committee shall review the aforementioned data sets and outcomes on a statewide level to include data from each region as well as data from: assurance measures, remediation, and findings and recommendations from Mortality Review and Risk Review Committees. Reports of the CQI Committee's actions shall be presented to an advisory stakeholder committee established through legislative action, the House Bill 144 Commission. The Medicaid agency retains final oversight of the operating agency.

Department and Cabinet officials participate in the quarterly HB 144 Committee meetings and will be providing information and data related to progress on the goals established by that body as well as the CQI plan. An Annual Report of HB 144 activity is submitted to the Legislative Review Committee on or by October 1 of each year.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

To equip various group and committee members with skill set for data analysis and trending, DDID shall work with the Human Development Institute to design and provide training. Members from these Committees and groups shall be required to participate: CQI; HB 144 Commission and sub-committee members; DDID staff; providers; case management entities; Mortality Review Committee; and Risk Management Advisory Committee. DMS personnel who do not participate in any of these committees will be invited to attend.

The Quality Improvement Strategy shall be reviewed for progress and needed revisions at least twice a year by the CQI committee with updates and recommendations provided to the DDID Management team. The focus of these reviews shall be utility of quality initiatives; validity of data; determination of best course of action; alternations needed; and information gained. This information will be communicated to all CQI stakeholders so that cycle continues.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department for Medicaid Services (DMS) or the designated state operating agency-DDID shall conduct annual utilization audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. DMS or its designee shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Person Centered Plan of Care (POC) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations.

DMS shall conduct annual audits of the financial management services (FMS) entities. These audits shall include a post-payment review of Medicaid reimbursement to the financial management agency for payment to the member's employees through participant directed opportunities. Auditing will be conducted through random sample of all participant directed member records. DMS shall utilize reports generated from MMIS reflecting each service billed for each member by financial management agency. Comparison of payments to member records, documentation and approved POC's shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved POC, DMS will initiate recoupment of the monies. Additional billing reviews shall be conducted based on issues identified during these post payment audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paidfor in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations areformulated, where appropriate.

Performance Measure:
Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the service delivery date.

Data Source : **Financial audits**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Annually**	**100% Review**
Operating Agency	**Continuously and Ongoing**	
Other: Medicaid Fiscal Agent for MMIS		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Monthly**
Other Specify: MMIS	**Continuously and Ongoing**

Performance Measure:
Number and Percent of Providers reviewed that resulted in an unsatisfactory audit resulting in recoupment. N= number of providers whose audit resulted in recoupment D= number of providers reviewed.

Data Source: **Record reviews, on-site**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
State Medicaid Agency	**Annually**	**Less than 100% Review**
Operating Agency		**Representative Sample** Confidence Interval = 95%
Other Medicaid Fiscal Agent for MMIS		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuously and Ongoing**
Other Specify: Medicaid Fiscal Agent for MMIS	

Performance Measure:
Number and percent of system defects identified in the Supports for Community Living waiver program and corrected on a quarterly basis.

Data Source (Select one): **Program logs**

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Quarterly**	**100% Review**

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Quarterly**

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.
DMS reviews the CMS-372 report for accuracy prior to submission.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DBHDID provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a plan of correction (POC). DMS and/or DDID perform trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their POC, the Office of Inspector General (OIG) would terminate the provider license and DMS would terminate the provider Medicaid enrollment.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Annually**
Operating Agency	**Continuous and Ongoing**

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently nonoperational.

No

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies
referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Paid claim data was reviewed for waiver participants for FY'09 and FY'10 which included total units paid per service, total unduplicated users, total cost, and average units of service and average cost. Data was trended forwarded through a review of historical information, factoring in rate of growth.

For new services, rates were established based on rates paid for other services that require similar education and experience. An Exceptional Supports Funding Protocol has been developed to provide extraordinary services to an individual experiencing challenging medical, psychiatric or maladaptive behavioral issues. It is estimated that 8% of individuals enrolled in the SCL waiver will have support needs beyond the normal service limits and/or reimbursement rate(s)typically receiving prior authorization.

The process for an exceptional supports request requires providers to submit a person centered plan of care based upon assessed needs as determined by Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST). The providers do not request a specific exceptional support tier, but instead exceptional supports are authorized based on specific information concerning the individual's needs and the plans to address those needs. DDID management staff must review and authorize any exceptional rates or limits.

The Exceptional Supports rate levels can authorize for 1.25, 1.5, 1.75, or 2 times the established, standard maximum rate for Day Training, Community Access, Personal Assistance, Respite, and Residential supports.

DMS works collaboratively with the operating agency to review historical usage and expenditures to develop the proposed rate structure. All rates must be approved by DMS and are incorporated into Medicaid state regulations, which are subject to public comment when promulgated or amended.

An independent cost study will be conducted during the third waiver year to review the appropriateness of the rates.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's MMIS.

c. Certifying Public Expenditures

No. State or local government agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All waiver providers shall be enrolled with the Department for Medicaid Services (DMS), provider enrollment and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. The Department for Medicaid Services (DMS) or its designee shall conduct annual audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement

to the provider agency for services rendered to a waiver member. DMS shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, DMS shall initiate recoupment of the monies.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment

a. Method of payments – MMIS:

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements:

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

No. The State does not make supplemental or enhanced payments for waiver services.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.**

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. **Organized Health Care Delivery System.**

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs.

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds.

The following source(s) are used

Health care-related taxes or fees

For each source of funds indicated above, describe the source of the funds in detail:

Four entities in Kentucky pay health-care related taxes: hospitals, nursing facilities, home health agencies, and mental retardation service providers. These are broad-based taxes which apply to all Medicaid and non-Medicaid providers within the specified groups.

Through the biennium budget process, the Kentucky General Assembly allocates funds generated through these health-care related taxes to the Department for Medicaid Services as one funding source which contributes to the overall Medicaid budget. Health-care related tax receipts are not designated to be used for a particular program or purpose within the Medicaid budget.

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.**

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Fixed rates for these services do not include any margin for room and board related expenses. The provider contracts specify that room and board expenses must be covered from sources other than Medicaid. Providers of waiver services are contractually prohibited from billing for room and board expenses through Medicaid. Operating agency staff review individual records during both certification and utilization reviews to verify that the costs for room and board are in fact, excluded. Medicaid agency staff also verify during second level reviews.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

The rent and food expenses of an unrelated live-in caregiver, who does not hold the lease or own the residence, will be determined by dividing total household rent and food expenses by the number of residents in the home, including the caregiver. In other words, the caregiver is considered a resident in the home, and food and rent expenses are apportioned equally among all persons residing in the home. It is the responsibility of the Case Manager to document and report any waiver funds used to pay rent and food expenses of an unrelated live-in caregiver.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a.Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation.

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8
Year	**Factor D**	**Factor D'**	**Total D+D'**	**Factor G**	**Factor G'**	**Total G+G'**	**Difference (Col 7 less Column 4)**
1	73094.61	6743.34	79837.95	184819.97	4149.10	188969.07	109131.12
2	73643.16	6945.64	80588.80	190364.57	4273.57	194638.14	114049.34
3	74653.22	7154.01	81807.23	196075.51	4401.78	200477.29	118670.06
4	75400.71	7368.63	82769.34	201957.77	4533.83	206491.60	123722.26
5	77076.97	7589.69	84666.66	208016.50	4669.85	212686.35	128019.69

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	**3767**	**3767**
Year 2	**4055**	**4055**
Year3	**4101**	**4101**
Year4	**4151**	**4151**
Year 5	**4201**	**4201**

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a. The Average Length of Stay is based on data from the CMS 372 Lag Report for the period 09/01/2008 through 08/31/2009 which contains run out through 09/09/2010. Total days of Waiver coverage was 1,166,620. Total Unduplicated Waiver Members was 3,330. Dividing total days of enrollment for all participants by the number of unduplicated participants yields an average days per waiver Member of 350.3, resulting in an Average Length of Stay of 11.5 months.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Review of paid claim data for waiver participants for FY '09 and FY '10 which included total units paid per service, total unduplicated users, total cost, and average units of service and average cost. Data was trended forward through a review of historical information, factoring in rate of growth. For new services, rates were established based on rates paid for other services that require similar education and experience and on the activities included in the service definition. Average units and estimated users were projected based on the judgment of specialists who have knowledge of the service needs of the targeted population.

User Calculation: Expected users for waiver services that remained unchanged or slightly modified were determined based on reviews of the impact of new waiver services on existing waiver services, impacts to existing provider networks, and the state's program policy. Additional users were added to waiver services to account for transition of Members from the MFP program into each year of the Waiver Amendment. Based on review of the MFP service utilization patterns it was determined that the additional users were expected to utilize services in the same manner as found in the general SCL population. As such, the users for each service were adjusted accordingly.

Units per User Calculation: Reviews based on historical utilization, other states utilization for similar services, impacts to provider networks, impacts between new and existing waiver services, and state program policy were considered in determining expected units per user.

Cost per Unit Calculation: The cost per unit of new waiver services was determined based on the activities included in the service definition, review of other states reimbursements for similar services, provider qualifications for the service, the potential provider costs of providing the service, and state program policy. The cost per unit of waiver services that remained unchanged or slightly modified was determined based on review of other states reimbursements for similar services, current provider cost of providing services versus existing reimbursement, provider qualifications and state program policy. **The cost per unit has a blended rate for services where the exceptional rate protocol is applicable**. It is estimated that 8% of the participants will need an exceptional rate. Of those, the distribution of intensity is projected as follows: 40% @ 1.25 times regular rate, 35% @ 1.5 times regular rate, 20% @ 1.75 times regular rate, and 5% @2.0 times regular rate.

Factor D Calculation: Total costs for each waiver service were calculated as the product of users, units per user and cost per unit. All waiver service costs for each waiver year were totaled and divided by the unduplicated Waiver Participants resulting in Factor D estimates.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J- 1. The basis of these estimates is as follows:

The Factor D' is based on data from the CMS 372 Lag Report for the period 09/01/2008 through 08/31/2009 which contains run out through 09/09/2010. The average per capita acute care services expenditures for acute care services to Waiver Members was calculated to be $6,356.24. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G is based on data from the CMS 372 Lag Report for the period 09/01/2008 through 08/31/2009 which contains run out through 09/09/2010. The average per capita institutional services expenditures was calculated to be $174,210.55. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300. Each Waiver Year per capita was then adjusted by a factor of 1.25. The factor was determined based on the Waiver Member Average Length of Stay of 11.5 months versus the Institutional Member Average Length of Stay of 9.2 months based on data from the CMS 372.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' is based on data from the CMS 372 Lag Report for the period 09/01/2008 through 08/31/2009 which contains run out through 09/09/2010. The average per capita acute care services expenditures for institutional members was calculated to be $3,910.92. This per capita was trended forward to each Waiver Year using an annual medical costs trend factor of 1.0300. Each Waiver Year per capita was then adjusted by a factor of 1.25. The factor was determined based on the Waiver Member Average Length of Stay of 11.5 months versus the Institutional Member Average Length of Stay of 9.2 months based on data from the CMS 372.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components"* to add these components.

Waiver Services
Case Management
Community Access
Day Training
Personal Assistance
Residential Support Level 1
Respite
Shared Living
Supported Employment
Occupational Therapy
Physical Therapy
Speech Therapy
Community Guide
Goods and Services
Natural Supports Training
Transportation
Assessment/Reassessment
Community Transition
Consultative Clinical and Therapeutic Service
Environmental Accessibility Adaptation Services
Person Centered Coaching
Positive Behavior Supports
Residential Support Level 2
Specialized Medical Equipment and Supplies
Technology Assisted Level! Residential Support
Vehicle Adaptation

d. **Estimate of Factor D**.
i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Case Management Total	Monthly	3767	11	320		13,259,840.00
Community Access Total						12,206,459.20
Community Access Individual	15 min	654	2080	8.31	11,304,259.20	
Community Access	15 min	110	1040	4.00	457,600.00	
CDO Community Access Individual	15 min	25	2080	8.31	432,120.00	
CDO Community Access	15 min	3	1040	4.00	12,480.00	
Day Training Total						50,680,283.84
Day Training I	15 min	3140	6289	2.32	45,814,107.20	
Day Training II	15 min	244	6289	3.00	4,603,548.00	
CDO Day Training	15 min	18	6289	2.32	262,628.64	
Personal Assistance Total						3,704,762.88
Personal Assistance	15 min	181	2912	5.89	3,104,454.08	
CDO Personal Assistance	15 min	35	2912	5.89	600,308.80	
Residential Support Level I Total						150,609,128.98
3 or fewer residents	Daily	2594	319	177.85	14,716,8385.10	
4 or more residents	Daily	79	322	135.26	3,440,743.88	
Respite Total						3,658,620.00
Respite	15 min	357	3500	2.81	3,511,095.00	
CDO Respite	15 min	15	3500	2.81	147,525.00	

Waiver Year 1 Continued (Page 2 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
CDO Shared Living	Monthly	8	11	600		52,800.00
Supported Employment Total						3,035,025.00
Supported Employment	15 min	325	846	10.25	2,818,237.50	
CDO Supported Employment	15 min	25	846	10.25	216,787.50	
Occupational Therapy Total						768,240.00
Occupational Therapy	15 min	220	90	22.17	438,966.00	
Occupational Therapy Assistant	15 min	220	90	16.63	329,274.00	
Physical Therapy Total						224,884.80
Physical Therapy	15 min	92	63	22.17	12,8497.32	
Physical Therapy Assistant	15 min	92	63	16.63	96,387.48	
Speech Therapy	15 min	477	132	22.17		139,5911.88
CDO Community Guide	15 min	78	120	8.00		74,880.00
CDO Goods & Services	Per Item	10	3	500		15,000.00
CDO Natural Supports Training	Per Event	30	5	200		30,000.00
CDO Transportation	Monthly	73	11	360		289,080.00
Assessment/Reassessment	Annual	3767	1	100		376,700.00
Community Transition	Event	40	1	2000		80,000.00
Consultative Clinical & Therapeutic	15 min	834	92	22.50		1,726,380.00
CDO Environmental Accessibility	Per Item	42	1	8000		336,000.00

Year 1 Continued (page 3 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Person Centered Coaching	15 min	440	552	5.75		1,396,560.00
Positive Behavior Supports	Per Plan	301	1	665		200,165.00
Residential Support Level II Total						30,073,853.90
12 or more hours per day	Daily	707	287	147.10	29,847,913.90	
Less than 12 hours per day	Daily	10	286	79	225,940.00	
Specialized Medical Equipment	Per Item	661	4	374.6		990,442.40
Technology assisted Level I Residential	Daily	4	286	79		90,376.00
Vehicle Adaptation	Per Item	12	1	6000		72,000.00

GRAND TOTAL:	**275,347,393.88**
Total Estimated Unduplicated Participants:	**3767**
Factor D (Divide total by number of participants):	**73,094.61**
Average Length of Stay on the Waiver:	11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Case Management Total	Monthly	4055	11	320		1,4273,600.00
Community Access Total						14,521,104.00
Community Access Individual	15 min	781	2080	8.30	13,483,184.00	
Community Access	15 min	122	1040	4.00	507,520.00	
CDO Community Access Individual	15 min	30	2080	8.30	517,920.00	
CDO Community Access	15 min	3	1040	4.00	12,480.00	
Day Training Total						53,347,574.52
Day Training I	15 min	3305	6289	2.32	48,221,536.40	
Day Training II	15 min	257	6289	3.00	4,848,819.00	
CDO Day Training	15 min	19	6289	2.32	277,219.12	
Personal Assistance Total						4,189,086.72
Personal Assistance	15 min	197	2912	5.89	3,396,090.88	
CDO Personal Assistance	15 min	46	2912	5.89	792,995.84	
Residential Support Level I Total						161,739,114.32
3 or fewer residents	Daily	2765	322	177.85	158,336,287.20	
4 or more residents	Daily	77	326	135.26	3,402,827.12	
Respite Total						4,429,290.60
Respite	15 min	397	3780	2.81	4,216,854.60	
CDO Respite	15 min	20	3780	2.81	212,436.00	

Waiver Year 2 Continued (Page 2 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
CDO Shared Living	Monthly	10	11	600		66,000.00
Supported Employment Total						3,277,827.00
Supported Employment	15 min	351	846	10.25	3,043,696.50	
CDO Supported Employment	15 min	27	846	10.25	234,130.50	
Occupational Therapy Total						81,1075.20
Occupational Therapy	15 min	201	104	22.17	463,441.68	
Occupational Therapy Assistant	15 min	201	104	16.63	347,633.52	
Physical Therapy Total						232,916.40
Physical Therapy	15 min	87	69	22.17	133,086.51	
Physical Therapy Assistant	15 min	87	69	16.63	99,829.89	
Speech Therapy	15 min	482	133	22.17		1,421,230.02
CDO Community Guide	15 min	80	120	8		76,800.00
CDO Goods & Services	Per Item	11	3	500		16,500.00
CDO Natural Supports Training	Per Event	33	5	200		33,000.00
CDO Transportation	Monthly	82	11	360		324,720.00
Assessment/Reassessment	Annual	4055	1	100		405,500.00
Community Transition	Event	40	1	2000		80,000.00
Consultative Clinical & Therapeutic	15 min	850	92	22.50		1,759,500.00
CDO Environmental Accessibility	Per Item	44	1	8000		352,000.00

Year 2 Continued (page 3 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Person Centered Coaching	15 min	585	734	5.75		2,468,992.50
Positive Behavior Supports	Per Plan	324	1	665		215,460.00
Residential Support Level II Total						33,138,063.60
12 or more hours per day	Daily	762	290	147.10	32,521,626.60	
Less than 12 hours per day	Daily	27	289	79	616,437.00	
Specialized Medical Equipment	Per Item	656	5	374.6		1,228,688.00
Technology assisted Level I Residential	Daily	6	286	79		136,986.00
Vehicle Adaptation	Per Item	13	1	6000		78,000.00

GRAND TOTAL:	**298,623,028.88**
Total Estimated Unduplicated Participants:	**4055**
Factor D (Divide total by number of participants):	**73,643.16**
Average Length of Stay on the Waiver:	11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Case Management Total	Monthly	4101	11	320		14,435,520.00
Community Access Total						18,219,760.00
Community Access Individual	15 min	987	2080	8.30	17,039,568.00	
Community Access	15 min	123	1040	4.00	511,680.00	
CDO Community Access Individual	15 min	38	2080	8.30	656,032.00	
CDO Community Access	15 min	3	1040	4.00	12,480.00	
Day Training Total						52,721,944.80
Day Training I	15 min	3266	6289	2.32	47,652,507.68	
Day Training II	15 min	254	6289	3.00	4,792,218.00	
CDO Day Training	15 min	19	6289	2.32	277,219.12	
Personal Assistance Total						4371319.68
Personal Assistance	15 min	198	2912	5.91	3,407,564.16	
CDO Personal Assistance	15 min	56	2912	5.91	963,755.52	
Residential Support Level I Total						162828846.50
3 or fewer residents	Daily	2762	325	177.85	159,647,052.50	
4 or more residents	Daily	71	330	135.26	3,181,794.00	
Respite Total						4,996,966.80
Respite	15 min	397	3780	2.81	4,723,160.40	
CDO Respite	15 min	15	3780	2.81	273,806.40	

Waiver Year 3 Continued (Page 2 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
CDO Shared Living	Monthly	10	11	600		66,000.00
Supported Employment Total						3,668,044.50
Supported Employment	15 min	393	846	10.25	3,407,899.50	
CDO Supported Employment	15 min	30	846	10.25	260,145.00	
Occupational Therapy Total						747,986.40
Occupational Therapy	15 min	162	119	22.17	427,393.26	
Occupational Therapy Assistant	15 min	162	119	16.63	320,593.14	
Physical Therapy Total						194,620.80
Physical Therapy	15 min	66	76	22.17	111,204.72	
Physical Therapy Assistant	15 min	66	76	16.63	83,416.08	
Speech Therapy	15 min	467	134	22.17		1,387,354.26
CDO Community Guide	15 min	84	120	8.00		80,640.00
CDO Goods & Services	Per Item	12	3	500		18,000.00
CDO Natural Supports Training	Per Event	36	5	200		36,000.00
CDO Transportation	Monthly	91	11	360		360,360.00
Assessment/Reassessment	Annual	4101	1	100		410,100.00
Community Transition	Event	10	1	2000		20,000.00
Consultative Clinical & Therapeutic	15 min	860	92	22.50		1,780,200.00
CDO Environmental Accessibility	Per Item	46	1	8000		368,000.00

Year 3 Continued (page 3 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Person Centered Coaching	15 min	547	916	5.75		2,881,049.00
Positive Behavior Supports	Per Plan	328	1	665		218,120.00
Residential Support Level II Total						34,596,231.60
12 or more hours per day	Daily	780	293	147.10	33,627,375.60	
Less than 12 hours per day	Daily	42	292	79	968,856.00	
Specialized Medical Equipment	Per Item	647	6	374.6		1,454,197.20
Technology assisted Level I Residential	Daily	9	292	79		207,612.00
Vehicle Adaptation	Per Item	14	1	6000		84,000.00

GRAND TOTAL:	**306,152,873.54**
Total Estimated Unduplicated Participants:	**4101**
Factor D (Divide total by number of participants):	**74,653.22**
Average Length of Stay on the Waiver:	11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table

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Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Case Management Total	Monthly	4151	11	320		14,611,520.00
Community Access Total						22,043,424.00
Community Access Individual	15 min	1200	2080	8.30	20,716,800.00	
Community Access	15 min	125	1040	4.00	520,000.00	
CDO Community Access Individual	15 min	46	2080	8.30	794,144.00	
CDO Community Access	15 min	3	1040	4.00	12,480.00	
Day Training Total						52,125,496.04
Day Training I	15 min	3229	6289	2.32	47,112,659.92	
Day Training II	15 min	251	6289	3.00	4,735,617.00	
CDO Day Training	15 min	19	6289	2.32	277,219.12	
Personal Assistance Total						4,491,789.12
Personal Assistance	15 min	199	2912	5.91	3,424,774.08	
CDO Personal Assistance	15 min	62	2912	5.91	1,067,015.04	
Residential Support Level I Total						164,825,835.54
3 or fewer residents	Daily	2766	329	177.81	161,809,589.34	
4 or more residents	Daily	66	335	136.42	3,016,246.20	
Respite Total						5,487,930.00
Respite	15 min	397	4340	2.81	5,170,849.60	
CDO Respite	15 min	15	4340	2.81	317,080.40	

Waiver Year 4 Continued (Page 2 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
CDO Shared Living	Monthly	10	11	600		66,000.00
Supported Employment Total						4,066,933.50
Supported Employment	15 min	436	846	10.25	3,780,774.00	
CDO Supported Employment	15 min	33	846	10.25	286,159.50	
Occupational Therapy Total						733,475.20
Occupational Therapy	15 min	139	136	22.17	419,101.68	
Occupational Therapy Assistant	15 min	139	136	16.63	314,373.52	
Physical Therapy Total						189,033.60
Physical Therapy	15 min	58	84	22.17	10,8012.24	
Physical Therapy Assistant	15 min	58	84	16.63	81,021.36	
Speech Therapy	15 min	463	135	22.17		1,385,735.85
CDO Community Guide	15 min	90	120	8.00		86,400.00
CDO Goods & Services	Per Item	12	3	500		18,000.00
CDO Natural Supports Training	Per Event	40	5	200		40,000.00
CDO Transportation	Monthly	100	11	360		396,000.00
Assessment/Reassessment	Annual	4151	1	100		415,100.00
Community Transition	Event	10	1	2000		20,000.00
Consultative Clinical & Therapeutic	15 min	870	92	22.50		1,800,900.00
CDO Environmental Accessibility	Per Item	48	1	8000		384,000.00

Year 4 Continued (page 3 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Person Centered Coaching	15 min	540	916	5.75		2,844,180.00
Positive Behavior Supports	Per Plan	332	1	665		220,780.00
Residential Support Level II Total						359,100.00
12 or more hours per day	Daily	799	296	147.05	34,777,913.20	
Less than 12 hours per day	Daily	59	296	79	1,379,656.00	
Specialized Medical Equipment	Per Item	648	8	374.6		1941926.40
Technology assisted Level I Residential	Daily	11	296	79		257,224.00
Vehicle Adaptation	Per Item	15	1	6000		90,000.00

GRAND TOTAL:	**312,988,330.05**
Total Estimated Unduplicated Participants:	**4151**
Factor D (Divide total by number of participants):	**75,400.71**
Average Length of Stay on the Waiver:	11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Case Management Total	Monthly	4201	11	320		14,787,520.00
Community Access Total						25,962,580.80
Community Access Individual	15 min	1417	2080	8.31	24,492,561.60	
Community Access	15 min	126	1040	4.00	524,160.00	
CDO Community Access Individual	15 min	54	2080	8.31	933,379.20	
CDO Community Access	15 min	3	1040	4.00	12,480.00	
Day Training Total						51,499,866.32
Day Training I	15 min	3190	6289	2.32	46,543,631.20	
Day Training II	15 min	248	6289	3.00	4,679,016.00	
CDO Day Training	15 min	19	6289	2.32	277,219.12	
Personal Assistance Total						4,560,628.80
Personal Assistance	15 min	198	2912	5.91	3,407,564.16	
CDO Personal Assistance	15 min	67	2912	5.91	1,153,064.64	
Residential Support Level I Total						167,396,495.82
3 or fewer residents	Daily	2775	333	178.08	164,559,276.00	
4 or more residents	Daily	62	339	134.99	2,837,219.82	
Respite Total						5,919,883.20
Respite	15 min	428	4620	2.81	5,556,381.60	
CDO Respite	15 min	28	4620	2.81	363,501.60	

Waiver Year 5 Continued (Page 2 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
CDO Shared Living	Monthly	10	11	600		66,000.00
Supported Employment Total						4,474,494.00
Supported Employment	15 min	480	846	10.25	4,162,320.00	
CDO Supported Employment	15 min	36	846	10.25	312,174.00	
Occupational Therapy Total						709,652.00
Occupational Therapy	15 min	118	155	22.17	405,489.30	
Occupational Therapy Assistant	15 min	118	155	16.63	304,162.70	
Physical Therapy Total						178,480.00
Physical Therapy	15 min	50	92	22.17	101,982.00	
Physical Therapy Assistant	15 min	50	92	16.63	76,498.00	
Speech Therapy	15 min	463	136	22.17		1,396,000.56
CDO Community Guide	15 min	95	120	8.00		91,200.00
CDO Goods & Services	Per Item	18	2	500		18,000.00
CDO Natural Supports Training	Per Event	45	5	200		45,000.00
CDO Transportation	Monthly	109	11	360		431,640.00
Assessment/Reassessment	Annual	4201	1	100		420,100.00
Community Transition	Event	10	1	2000		20,000.00
Consultative Clinical & Therapeutic	15 min	870	92	22.50		1,800,900.00
CDO Environmental Accessibility	Per Item	50	1	8000		400,000.00

Year 5 Continued (page 3 of 3)

Waiver Service/Component	Unit	# Users	Avg. Units / User	Avg. Cost/Unit	Component Cost	Total Cost
Person Centered Coaching	15 min	530	916	5.75		2,791,510.00
Positive Behavior Supports	Per Plan	336	1	665		223,440.00
Residential Support Level II Total						37,729,225.30
12 or more hours per day	Daily	817	299	147.10	35,934,029.30	
Less than 12 hours per day	Daily	76	299	79	1,795,196.00	
Specialized Medical Equipment	Per Item	648	10	374.6		2,427,408.00
Technology assisted Level I Residential	Daily	15	299	79		354,315.00
Vehicle Adaptation	Per Item	16	1	6000		96,000.00

GRAND TOTAL:	**323,800,339.80**
Total Estimated Unduplicated Participants:	**4201**
Factor D (Divide total by number of participants):	**77,076.97**
Average Length of Stay on the Waiver:	11